FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: **CALIFORNIA**
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

Date: 3/31/2000

Reporting Period: 7/1/98 through 9/30/99

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Table of Contents

Table of Contents

Table of Contents

Section 1. Summary of Key Accomplishments of Your CHIP Program

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

The period from Healthy Families Program (HFP) / Medi-Cal for Children (MCC) implementation in July 1998 to September 1999 produced significant achievements with regard to policy development, creation of a purchasing and outreach infrastructure, and establishment of a strong base of enrollment.

An *outreach and education* network of 17,000 partners, representing over 4,000 Community Based Organizations in all geographical areas of the state, has been successful in reaching potential enrollees. Over 350,000 applications have been distributed to interested parties. Program recognition throughout the State has been established through a comprehensive advertising and promotional effort employing television, radio, print, public relations, and collaboration with influential local, state, and national organizations.

Language barriers have been addressed through the use of application materials and toll-free information lines communicated in eleven languages.

Geographical and ethnic targeting has been successful with over 60% of total participants enrolled in California's six largest counties. The remaining participants are spread over 52 smaller counties with a median of 1,000 subscribers per county. Over 80% of total statewide enrollment is represented in the Latino, Asian/Pacific Islander, or African American ethnic groups.

The application process along with eligibility determination and coordination has been accelerated by the employment of state of the art administrative systems, such as *"Single Point of Entry"*, that allows integration between Medi-Cal and HFP along with providing real time answers to subscribers' questions.

A toll-free system of telephone services that has been utilized by over 1,000,000 callers illustrates the scope of the SCHIP program's success.

Contractual relationships with 30 health, dental and vision insurance organizations have been successfully executed. All 58 counties in California have at least one health plan. In rural areas of the state, where access to care and reaching immigrant populations is a challenge, partnerships have been created with participating health plans and local community clinics to provide expanded access to services. Innovative approaches to delivery of medical care have been successful in providing a win-win environment for both subscribers and health plans.

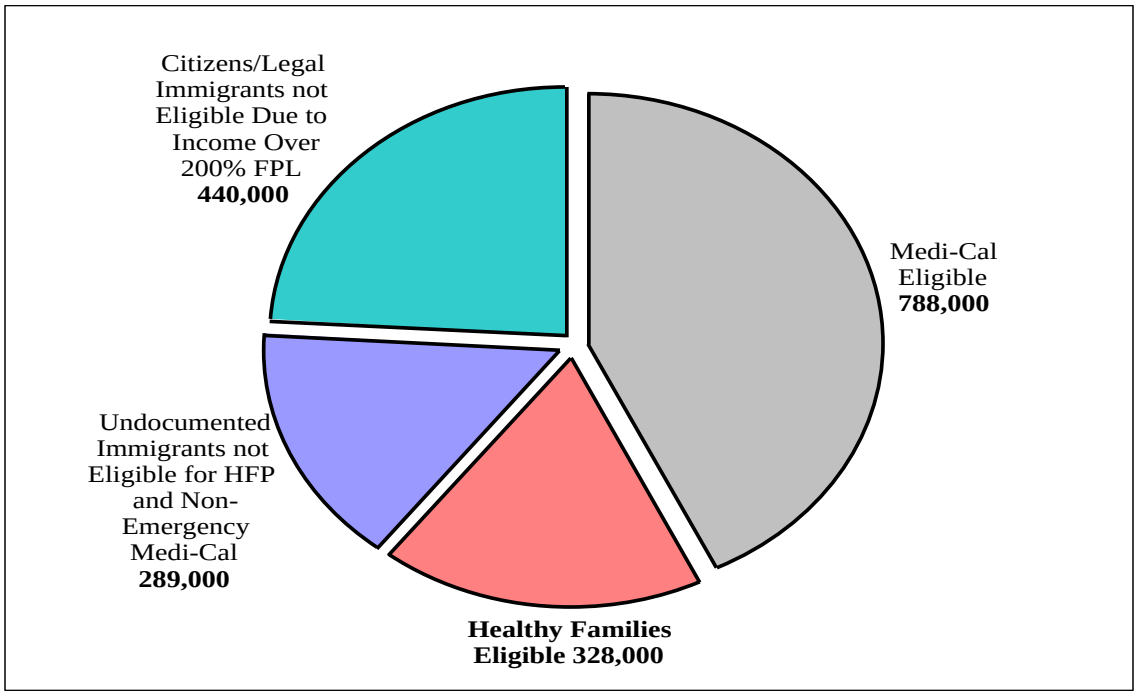
1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

The estimated baseline number of uncovered low-income children eligible for the Healthy Families Program (SCHIP) as of 9/30/99 was **328,000**.

The estimated baseline number of uncovered low-income children eligible for the Healthy Families Program (SCHIP) submitted on the *HCFA 1998 annual report* was **400,000.**

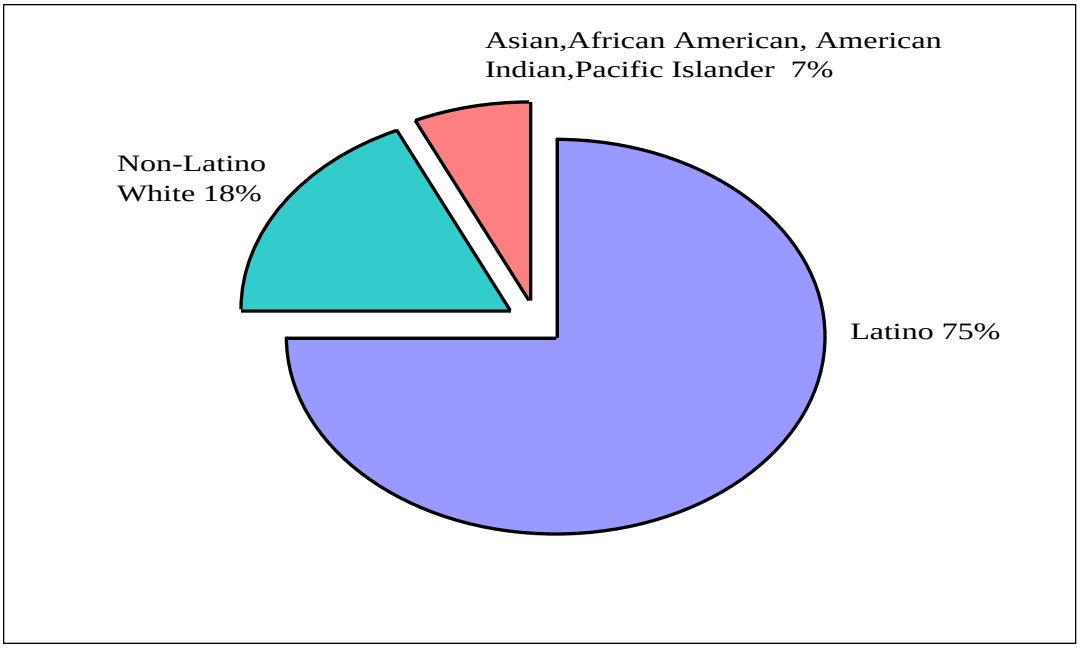
The difference is in the timing of data used. The 400,000 estimate was based on 1997 CPS data, while the 328,000 is based on 1998 CPS data.

Estimate of Uninsured Children – By Eligibility Classification

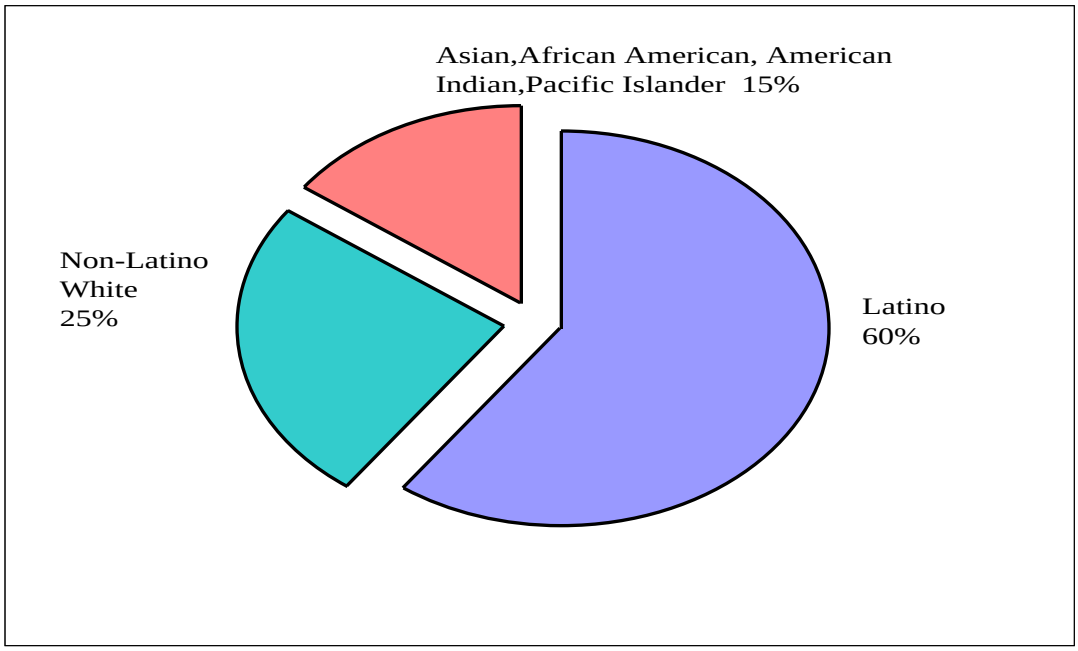


Source: State of Health Insurance in California, 1998. UCLA Center for Health Policy Research

Uninsured Children Eligible for the HFP – By Ethnic Group



Uninsured Children Eligible for Medi-Cal – By Ethnic Group



Source State of Health Insurance in California, 1998. UCLA Center for Health Policy Research

1.1.1 What are the data source(s) and methodology used to make this estimate?

The source data was the 1998 Current Population Survey (CPS) as analyzed by the UCLA Center for Health Policy Research. Technical notes can be found on the UCLA Website at: www.healthpolicy.ucla.edu/publication.html

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The UCLA Center estimated there were 2,027,040 children on Medi-Cal in the State in 1997. Actual DHS Medi-Cal eligibility statistics for January 1998, show there were 2,597,955 children ages 0 to 18 years. It is unclear to what degree the estimate of 788,000 children shown as being Medi-Cal eligible and not enrolled is apparent under-reporting of over 500,000 enrolled Medi-Cal children.

UCLA Center recommends the estimate be viewed as an approximation for two reasons:

1) The CPS sample sizes of uninsured children in these subgroups are small, and consequently, result in unstable and imprecise estimates; and

2) The CPS does not ask respondents whether they are documented or undocumented immigrants. The UCLA Center, therefore, modeled documentation status in order to exclude from the estimates those children who would be ineligible for any public coverage other than emergency Medi-Cal services.

The UCLA Center further recommends that the estimated population be viewed as a range. The HFP population should be estimated at between 259,000 to 397,000 children, and the MCC population should be estimated at 681,000 to 895,000 uninsured children.

The *Urban Institute* also provides a range of estimates of the number of uninsured Medi-Cal eligible children in California. Their analysis, based on unedited CPS data, estimates 904,000 Medicaid eligible uninsured children, while they estimate 307,000 Medicaid eligible uninsured children based on CPS data adjusted by the *Urban Institute's* TRIM2 microsimulation model.

The CPS is widely believed to undercount Medicaid enrollment and therefore overstate the number of uninsured children. The *Urban Institute's* TRIM2 model attempts to adjust for the Medicaid undercount by aligning Medicaid enrollment on the CPS to HCFA administrative data. The adjustment imputes enrollment to individuals meeting Medicaid eligibility criteria to match HCFA's estimates of individuals ever on the Medicaid program at any time during the year. This is consistent with the way the CPS poses questions about insurance coverage. It will overstate the number on Medicaid and understate the uninsured at a point in time.

The number of children who are eligible for Medicaid as well as the number of uninsured at any point in time probably lies between the CPS and the *Urban Institute's* estimates.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

California has made significant progress in increasing the number of children with creditable health coverage. Enrollment data from July 1998 through September 1999 has shown strong growth. Within 18 months, California enrolled over 170,000 Healthy Families Program children and directed over 4,000 children per month to the Medicaid Program. The HFP enrollment represents 54% of all projected eligible uninsured children. The program continues to mature and improve while momentum advances.

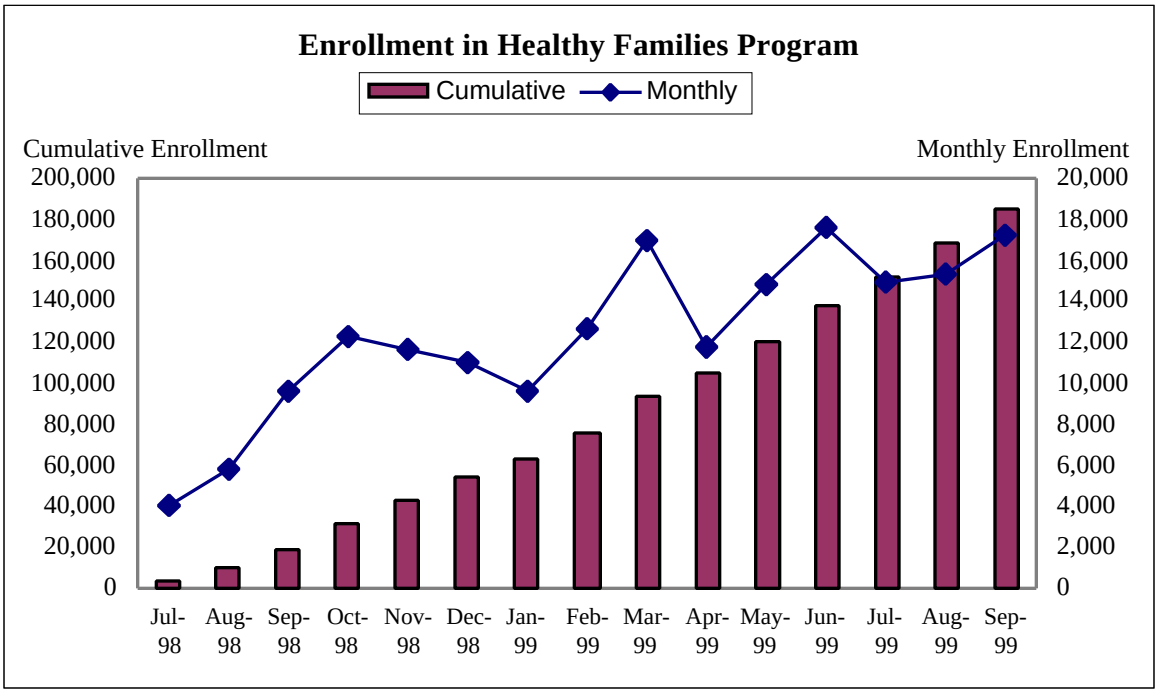
An extensive infrastructure has been assembled highlighted by California's innovative partnership approach to outreach and education. It has succeeded in reaching over 450,000 interested parties. Our customer oriented administrative systems have the capacity to complete enrollment within 20 days, communicate in a variety of languages, and provide a simple and relatively seamless approach to eligibility determination, enrollment and referral to other child health support agencies.

With 30 health, dental and vision plans available, enrollees are provided with a wide variety of choices. In addition, innovative approaches to lowering costs, extending access and improving quality have been implemented.

<u>Total number of children enrolled in the Healthy Families Program</u>
The total number of children enrolled in the Healthy Families Program (SCHIP) as of 9/30/99 was 155,993. The total number enrolled at any time during the period 7/1/98 (program implementation) to 9/30/99 was **178,725.**

Average monthly enrollment growth during calendar year 1998 was ***9,000*** per month, while calendar year 1999, January through September, achieved average new enrollment of ***14,500*** per month.

The Latino population comprises the majority of enrollment, 60% of the enrolled base, along with posting the fastest growth rates during calendar year 1999. The Latino population increased at 9% per month from January 1999 through September 1999. White, African American and Asian/Pacific Islander populations experienced monthly growth rates between 5% and 6%.


Enrollment in Healthy Families Program
Cumulative
Monthly
Cumulative Enrollment
Monthly Enrollment
200,000
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Jul-98
Aug-98
Sep-98
Oct-98
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Apr-99
May-99
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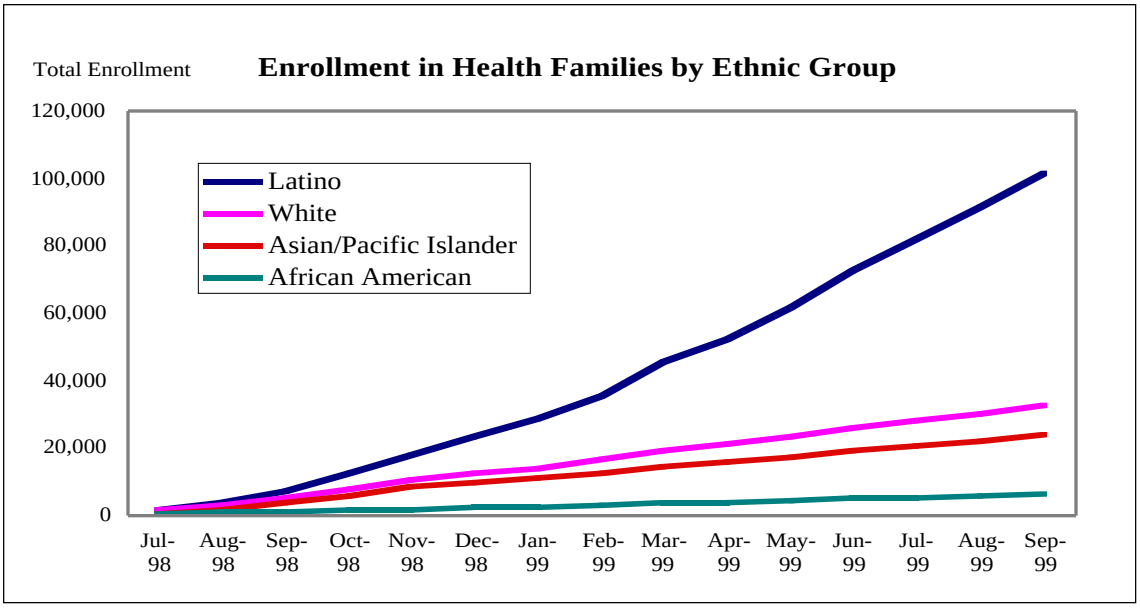
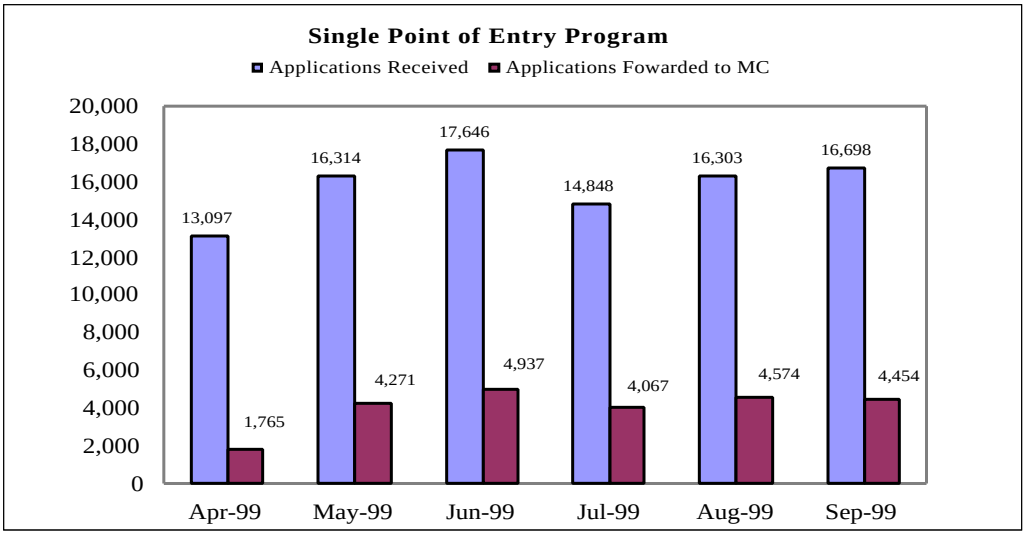
Jul-99
Aug-99
Sep-99


Total Enrollment
Enrollment in Health Families by Ethnic Group
120,000
100,000
80,000
60,000
40,000
20,000
0
Latino
White
Asian/Pacific Islander
African American
Jul-98
Aug-98
Sep-98
Oct-98
Nov-98
Dec-98
Jan-99
Feb-99
Mar-99
Apr-99
May-99
Jun-99
Jul-99
Aug-99
Sep-99

New Medicaid enrollment ascribed to SCHIP outreach

The Healthy Families Program's application includes a method of identifying and routing prospective Medicaid participants to the Medicaid program. The process is called *"Single Point of Entry"* and has been successful in directing eligible participants to California's Medi-Cal program. The State implemented this process in March 1999 and has directed approximate***ly 25,000*** applications to Medi-Cal through 9/30/99. This represented approximately 25% of the total HFP/MCC applicants during this period.

Based on the application trends attributable to "*Single Point of Entry*", it can be forecast that ***4,500*** applications for Medi-Cal eligible children per month or ***54,000*** per year will be forwarded to Medi-Cal through the combined HFP/MCC outreach campaign.



Crowd Out Efforts to reduce the shift from public to private coverage.

In order to prevent crowd-out, applicants to the Healthy families Program and Medi-Cal for Children must answer questions about their previous health coverage. Data collected from the implementation of the Healthy Families Program indicates that 3.7% of successful applicants had coverage through an employer within the prior 90 day period. Of the applicants who indicated they had coverage within the prior 90 days, 60% indicated loss of employment, 10% had an employer who discontinued benefits to all employees, 5% cited end of COBRA coverage, and the remainder indicate "other" reasons. These numbers indicate that crowd-out has not affected the HFP to any significant degree.

1.2.1 What are the data source(s) and methodology used to make this estimate?

Responses for Total Number of Children Enrolled
Data Source: Application and enrollment data from the program's administrative vendor. This includes counts of applicants that have been enrolled and those who have disenrolled in the HFP.
Methodology: Data is sorted, extracted and reported from the administrative vendor's database to determine enrollment counts.

Responses for New Medicaid enrollment ascribed to SCHIP outreach
Data Source: Application and enrollment data from the program's administrative vendor.
Methodology: Application data is screened at the single point of entry based upon predetermined income eligibility formulas. These formulas and algorithms determine if the applicant is eligible for Medi-Cal or the Healthy Families Program and directs them to the appropriate program.

Responses for Crowd Out
Data Source: Application and enrollment data from the program's administrative vendor.
Methodology: This information is compiled and reported directly from application responses.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Responses for Total Number of Children Enrolled
This data is highly reliable. It is derived through enrollment statistics from the HFP administrative vendor.

Responses for New Medicaid enrollment ascribed to SCHIP outreach
This data is highly reliable relative to the hard numbers of referral from the single point of entry application screening process. It is derived through application statistics from the HFP administrative vendor.

Responses for Crowd Out
Data supplied by the HFP administrative vendor is deemed highly reliable. A number of studies have attempted to measure the extent of *"crowd out"*. The results differ depending on whether the data was cross sectional which is used to determine the probability of having a certain type of insurance at a given point in time, or longitudinal which tracks individuals' movement from one type of insurance to another over time.

Assessing "crowd out" as a result of the Healthy Families Program is further complicated by the relatively recent implementation of the program.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: ***List the State's strategic objectives for the CHIP program, as specified in the State Plan.***

Column 2: ***List the performance goals for each strategic objective.***

Column 3: ***For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.***

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

***Narrative 1.3.1.1* Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal Program**

The goal of increasing the percentage of Medi-Cal eligible children (0-18) enrolled in Medi-Cal during the implementation of the Healthy Families Program can be measured by the change in percentage of eligibles enrolled from program implementation (7/1/98) to the end of the evaluation period (9/30/99).

These following tables, along with the implied performance measures, are contingent upon the accuracy of the estimates of eligibles. California is using estimates supplied by the UCLA Center for Health Policy Research. These estimates have changed significantly during the HFP implementation. The authors are reluctant to provide precise projections and recommend that the estimated population be viewed as ranges. The MCC eligible but not enrolled population was estimated at 681,000 to 895,000 uninsured children during the reporting period. *(Please see page 5 – Question 1.1.2 for a discussion on the reliability of the estimate)*

With this in mind, the following table represents the percentage of eligibles enrolled based on the mid-range of estimates.

Percent of eligibles enrolled based on mid range estimate of uninsured children = 788,000

Period	Medi-Cal Eligibles	Medi-Cal Enrollment	Percent of Eligibles Enrolled
June 30, 1998 (Pre HFP)	3,424,550	2,636,550	77.0%
September 30, 1999	3,439,038	2,651,038	77.1%
Change from Healthy Families Implementation			.1%

Decrease in enrollment is concentrated within the 0-5 age category, offset by increases in the 6-18 age group. The following table delineates the age of enrollees:

Age Range	Pre-Implementation June 30, 1998	Post Implementation September 30, 1999	Change in Enrollment
0-18	2,636,550	2,651,038	14,488
0	189,413	185,836	(3,577)
1-5	883,466	851,216	(32,250)
6-12	982,373	1,006,584	24,211
13-18	581,298	607,402	26,104

The Kaiser Family Foundation's national study on Medicaid and Children suggests that the negative public image of welfare and the historical link between Medicaid and cash assistance has created barriers to Medicaid enrollment. These perceptions, however, should not necessarily be construed as people rejecting the Medicaid program; the challenge lies in further severing the association of Medicaid to welfare, and capitalizing on the positive feelings about coverage and affordability.
"Kaiser FF Medicaid and Children Overcoming Barriers to Enrollment Jan. 2000."

The policy implication of The Kaiser Family Foundation's national study on Medicaid and Children suggests that the policy changes described below can go a long way in promoting the positive aspects of the program and increasing enrollment.

This table delineates these policy changes and describes the strategies California has put in place to capitalize on them.

The policy implications changes	California Strategy
Create a Better Medicaid Product	At the start of the HFP, California eliminated asset tests for children under 19 eligible for no cost Medicaid. Expanded MC eligibility Implemented bridging month Accepted mail-in application
Streamline enrollment process	Implemented a user-friendly 4 page application. Developed single point of entry screening process.
Expand outreach and clearer communication of program information	Outreach infrastructure is built on partnerships with Community Based Organizations who are closest to the target population. Organizations have the ability to communicate in most languages spoken throughout California. Training has been provided to over 17,000 Certified Application Assistants. These services are available in 11 languages.
Simplification of eligibility criteria	Elimination of asset tests, use of 12 month continuous eligibility for HFP. *Single Point of Entry* process to determine placement in program. Simplified documentation requirements.

<u>Narrative 1.3.1.2</u> Reduce the percentage of uninsured children in target income families that have family income above no cost Medi-Cal.

The estimated baseline number of uncovered low-income children eligible for the Healthy Families Program (SCHIP) as of 9/30/99 was **328,000**. The total number of children ever enrolled from implementation to 9/30/99 was **178,725.**

Based on the downward revisions in the baseline of eligibles in 1998, we assumed no significant upward revisions in the baseline during the implementation period under review (July 1998 to September 30, 1999); the following equation represents the progress in reducing the uninsured within the target population:

<u>**D**enominator</u> – HFP eligible baseline *(see pages 3-5 - question 1.1 for detailed description)*

D = Estimated number of uninsured children in target income families
= 328,000

<u>**N**umerator</u> – Actual number of uninsured children insured under HFP during the reporting period.

N = Actual number of uninsured children insured under HFP during reporting period.
= 178,725

<u>**P**rogress toward goal</u> – Estimated reduction in the percentage of uninsured children in target income families that have family income above no cost Medi-Cal:

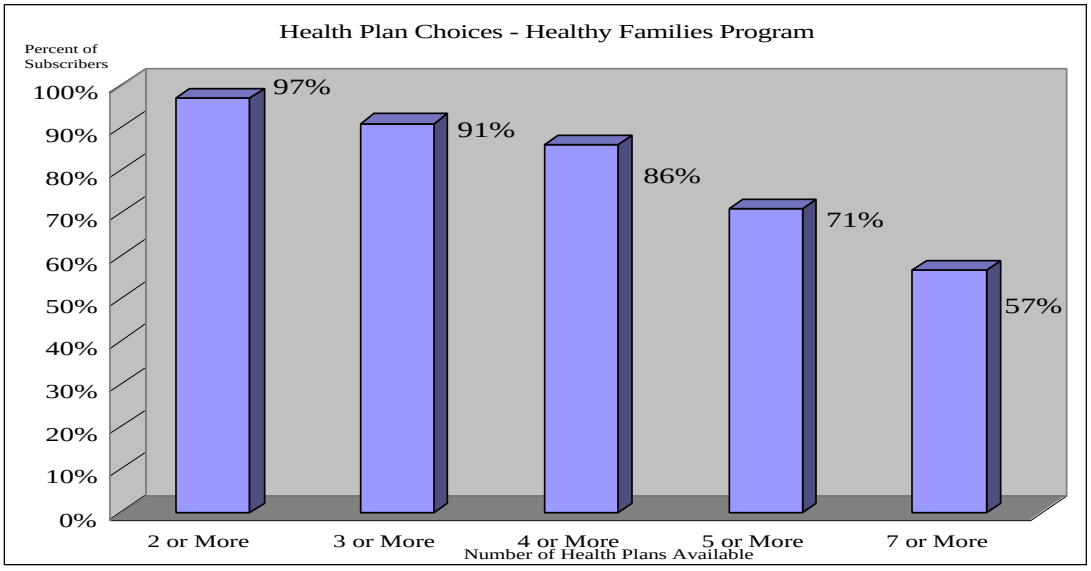
P = (N / D)= 178,725 / 328,000 = <u>54</u>%

This measure illustrates the relative speed of California's progress in meeting the goal. During 1998 many positive changes were implemented to attract, enroll, and retain the target population. The program has shown its greatest growth in numbers during the later half of the reporting period. We are especially pleased with the level and growth of the Hispanic component of the enrollee base.

Narrative 1.3.2.1 Provide each family with two or more health plan choices for their children.

Healthy Families Program offers a broad range of health plans for program subscribers. There are a total of 25 health plans participating. The progress in providing health plan choices has far exceeded the goal of two health plan choices for families. The data below describes the distribution of plans and subscribers:

- 97.3% of Subscribers have a choice of 2 or more health plans
- 91.3% of Subscribers have a choice of 3 or more health plans
- 86.4% of Subscribers have a choice of 4 or more health plans
- 71.2% of Subscribers have a choice of 5 or more health plans
- 57.0% of Subscribers have a choice of 7 or more health plans



***Narrative 1.3.3.1:* Assure Medi-Cal and HFP enrollment contractor provide written and telephone services spoken by target population.**

Applicants can receive enrollment instructions, a handbook and application in eleven languages. The joint application (Medi-Cal for Children and Healthy Families Program) is a simple user–friendly document with each question referenced and explained in detail. Color-coding is used to delineate areas and call attention to important facts.

The original application booklet began as a 28-page document with detailed instructions and information, developed as a collaborative effort with extensive advocacy involvement and focus group testing. After a negative response to the length and complexity of the document, the workgroup reconvened and developed the new application package that consists of a booklet containing four (4) pages to complete, three (3) pages of instructions, guidelines, and helpful hints on completing the questions.

A "Certified Application Assistant" (CAA) is available to assist families in completing the application. CAAs are community based trained persons and are located throughout the State. Each CAA is affiliated with an Enrolled Entity (EE). Enrolled Entities are public and private based organizations such as clinics, schools, and businesses. EEs are paid an assistance fee ($50) for each successful application. This service is free to the applicant.

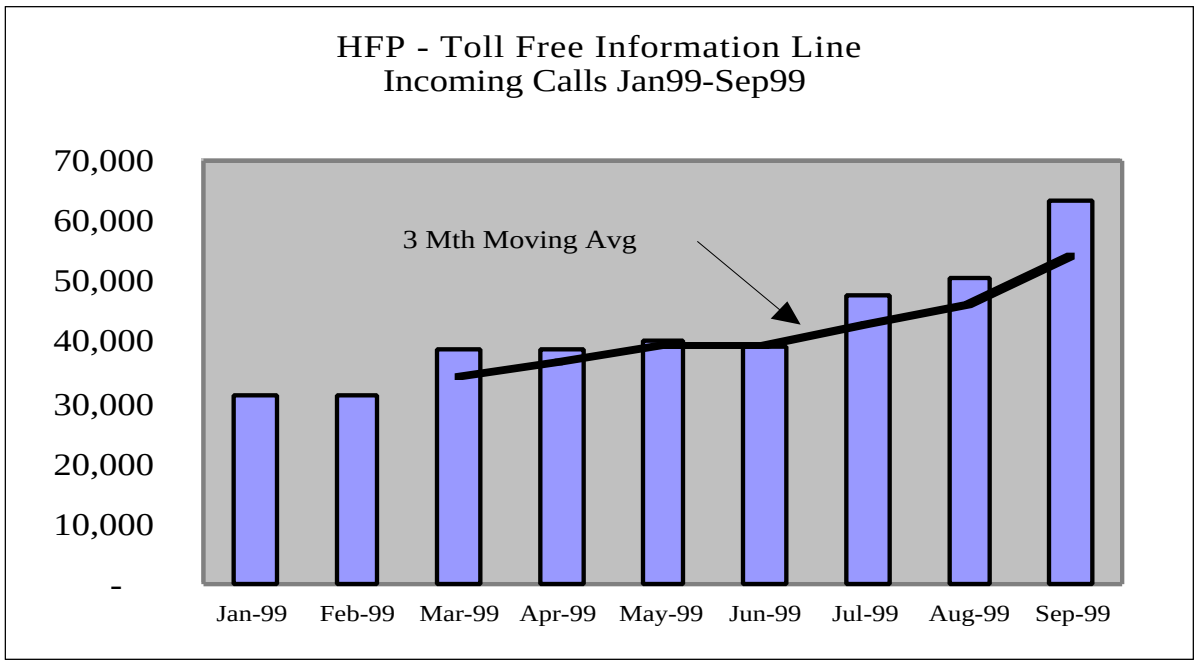
The Managed Risk Medical Insurance Board has a stand-alone website where program and application data are also available. The address is www.HealthyFamilies.ca.gov.

Toll free HFP Information Line, 1-800-880-5305, was established and is administered by MRMIB's contract with the administrative vendor, EDS. Enrollment specialists offer HFP information, enrollment assistance and status, account maintenance and billing information to families.

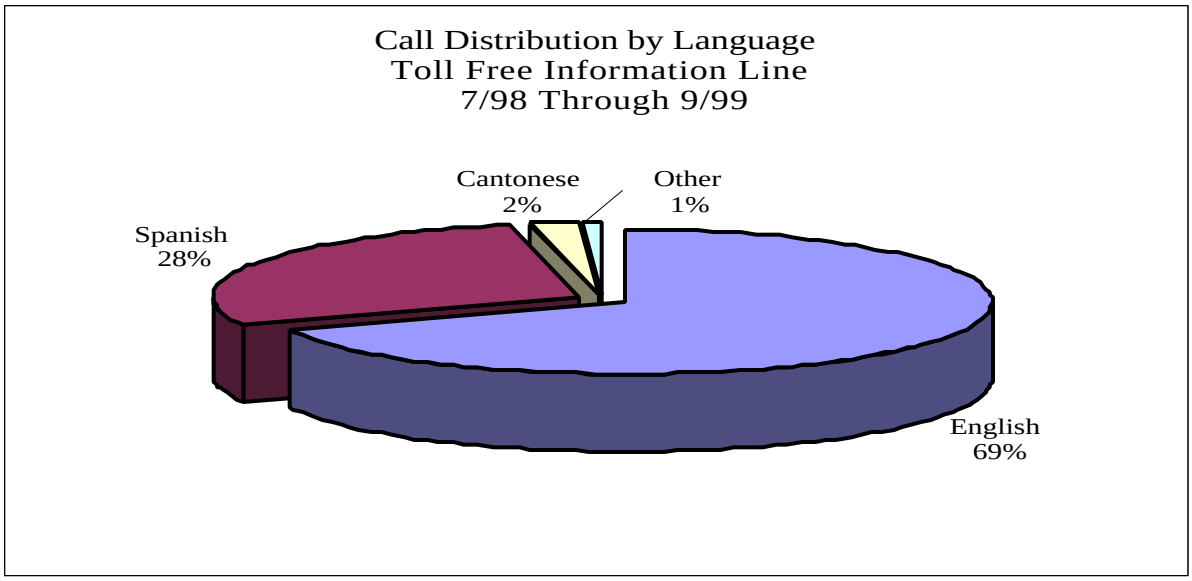
A team of operators proficient in the eleven designated languages in which campaign materials are published staffs the line. The following table describes frequency of calls by language:

Language	Program to Date	% of Total
English	456,371	68.50
Spanish	188,931	28.36
Cantonese	14,374	2.16
Korean	2,088	.31
Vietnamese	2,015	.30
Armenian	1,408	.21
Russian	391	.06
Cambodian	351	.05
Hmong	127	.02
Farsi	105	.02
Loa	95	.01

Toll Free HFP Information Line, 1-800-880-5305, has received over ***600,000*** calls from implementation in July 1998 through September 1999. The average number of calls per day during 1999 stands at approximately ***2,000***. Incoming calls have grown significantly during calendar year 1999. The following table displays monthly incoming calls along with a three month moving average.



The following graph displays the breakdown by language of the callers. The vast majority of contacts are either English or Spanish speaking.



***Narrative 1.3.4.1* Limit program cost to two percent of annual household income**

California is making significant progress in limiting Healthy Families Program cost to two percent of annual household income. The following table represents the aggregate distribution of income and premiums for enrollees from implementation to the reporting period 9/30/99. The *maximum* weighted average (based on mix of enrollees) program cost as a percent of income is **2.45%.**

This analysis assumes an average family size of three, 42% of enrollees receiving the $3/month discount for enrolling with a Community Provider Plan (please see narrative 3.7), and expending the maximum health copayment of $250. The $250 copayment equals 50 visits or prescriptions per year at $5 per visit. A total of **26** children, in all families, reached the $250 maximum for health benefits during the period July 1, 1998 to June 30, 1999. None reached the copayment maximum for dental or vision. If the average family made between 25 and 40 visits per year, the program cost would drop *below* **2%.**

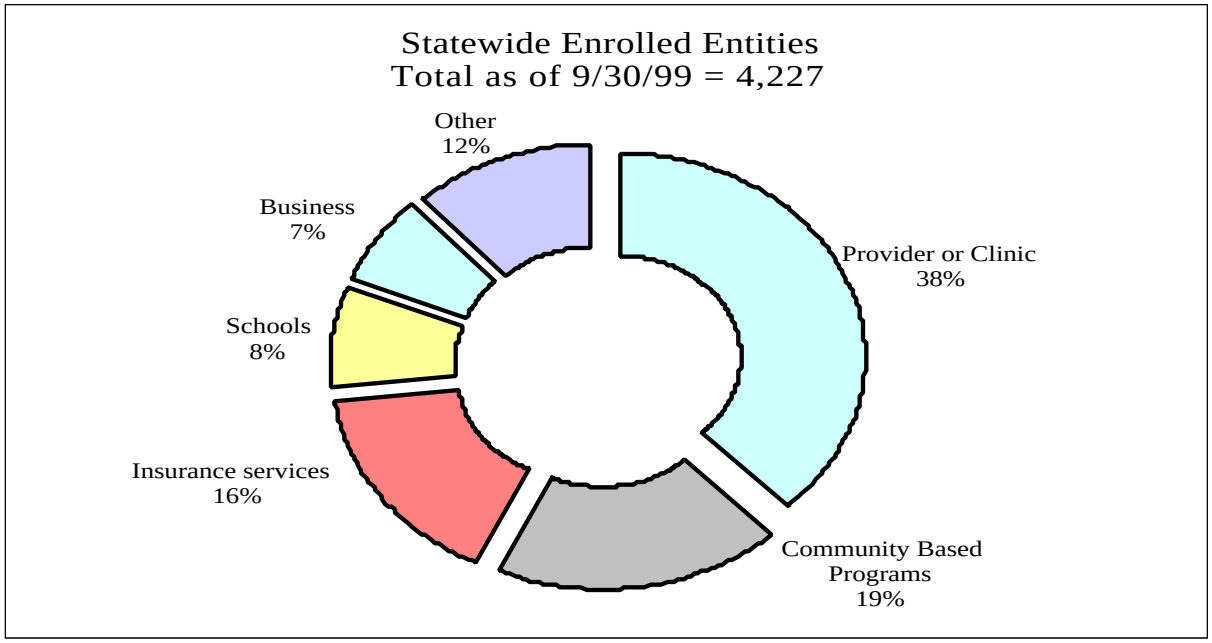
Aggregate Income and Premium Statistics

Countable Income Level	Percent Mix of Enrollees	Average Annual Premium (assuming 42% take $3 discount)	Maximum Allowable Health Copayments	Maximum Total Program Cost	Average Annual Income	Maximum Program Cost as a Percent of Income
Under 150% of FPL	**42%**	**$124**	**$250**	**$374**	**$13,884**	**2.69%**
Over 150% of FPL	**58%**	**$223**	**$250**	**$473**	**$20,822**	**2.27%**

<u>Narrative 1.3.6.1</u> Insure that a variety of entities experienced in working with target populations are eligible for an application assistance fee.

The Community Based Organizations(CBOs) are an integral part of the Healthy Families Program outreach strategy. A wide spectrum of CBOs are participating and being reimbursed for their application assistance via the application assistance fee program. As of 9/30/99, there were over 4,000 organizations participating. The following chart describes the breadth of participation. A total of $1 million was allocated to CBO outreach mini-contracts and a cumulative total of $3,255,500 for assistance fees during the reporting period July 1998 through September 1999. This represents a significant effort in utilizing this approach.

Of the over 4,000 "Enrolled Entities", 46% have submitted the documentation to receive a reimbursement for assisting a family in completing the application. The number of entities requesting reimbursement has increased by 72% from the beginning of 1999. The number of participating enrolled entities has grown by 42% since the beginning of 1999.

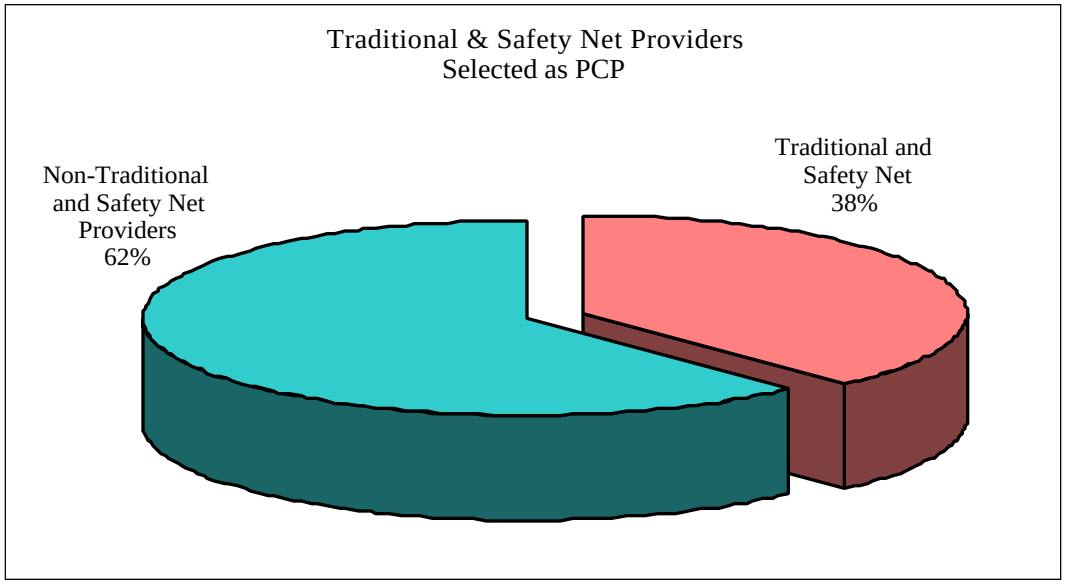


<u>Narrative 1.3.7.2</u> Increase the number of children enrolled who have access to a traditional or safety net providers as defined by MRMIB.

The MRMIB designed a traditional and safety net provider program that provides access to care in all areas of the State. As an incentive to include T&SN providers in their network, health plans with the highest percentage of traditional and safety net providers in their network are designated as a Community Provider Plan(CPP). Plans with the Community Provider Plan designation are offered at a $3 per child premium discount. T&SN providers are available in all areas and all HFP subscribers have access.

Thirty-eight percent (38%) of Healthy Families Program subscribers have chosen a traditional and safety net provider as their primary care physician. Additionally, 18 out of the 25 participating health plans are designated as a Community Provider Plan (CPP) in at least one county. Of all HFP subscribers, 42% are enrolled in the CPP and receive the $3 discount.

In 10 of California's 58 counties, the CPP had a score of 90% or greater which means significant participation of T&SN providers in HFP network.



Narrative 1.3.9 ***Insure no break in coverage as they access specialized services***

Children enrolled in the HFP are referred to the California Children's Services program or the county mental health departments, depending upon their special health care needs. These referrals may originate with the health plans participating in the HFP, or from other sources such as schools or families. As such, the numbers of children with special health care needs that are tracked by HFP are those children known by the plan and the county. To facilitate the tracking of these children, the State has implemented two administrative data systems that will be fully operational by December 31, 2000.

The State monitors access to services for children with special health care needs by holding routine meetings with health, dental and vision plans and the CCS and county mental health programs and through complaints received from subscribers. Annual subscriber grievance reports submitted by plans also allow the State to monitor access. The routine meetings with plans and the programs allow the State and plans to discuss any arising or foreseeable barriers to access, and ways to eliminate these barriers. Suggestions made by plans to improve access to services for children with special health care needs have resulted in changes in the administration of referrals. For example, changes in State law making referrals to CCS mandatory for plans has eliminated a "perceived" option of referral that was used by some plan providers who were not referring children to CCS. As another example, a special work group was formed to develop a standard referral protocol for children needing county mental health services.

During the reporting period, there were three complaints/grievances reported related to the CCS and county mental health process. The subject of these complaints was the coordination of services. By working with the plans involved and the local CCS and/or mental health programs, the coordination problems were effectively resolved.

Section 2. Background

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

_X__ ***Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)***

Name of program: Medi-Cal for Children
Date enrollment began (i.e., when children first became eligible to receive services):
March 1998

_X__ ***Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)***

Name of program(s): Healthy Families Program HFP, Access for Infants and Mothers (AIM) (existing program)
Date enrollment began (i.e., when children first became eligible to receive services): February 1992 for AIM July 1998 for Healthy Families

___ ***Other - Family Coverage***

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

___ ***Other - Employer-sponsored Insurance Coverage***

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ ***Other - Wraparound Benefit Package***

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

No.

2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

No.

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Medi-Cal California. California's largest public health insurance program serving children is Medicaid (known in California as Medi-Cal).

Affect on SCHIP Program Design:

As part of the Healthy Families Program, the State enacted a number of changes to Medi-Cal designed to ease the entry of Medi-Cal eligible children into the Medi-Cal system and establish a more consistent eligibility standard for children. Specifically the State enacted legislation to:

- Disregard resources of the parent and child, for children between ages 1-19 in the Federal Poverty Programs, thereby expanding coverage under Title XXI for children whose families meet Medi-Cal income standards but who have not met its resource standards. Medi-Cal disregarded resources also, expanding eligibility under Medi-Cal when families meet Medi-Cal income standards

- Provide one month of continuous eligibility to be used by families who no longer qualify for no share of cost Medi-Cal to transition to Healthy Families private insurance

- Require development of a simplified Medi-Cal form which can be mailed in; and make eligible for Medi-Cal at 100% or less of FPL, children under age 19 who were born before September 30, 1983 (children age 14-19). This means that children aged 6-19 are eligible at 100% or less of FPL

Child Health and Disability Prevention Program (CHDP**).** The CHDP program provides preventive health screening examinations for children with family incomes of less than 200 percent of the federal poverty level.

Affect on SCHIP Program Design

The CHDP program is integrated into the design of the Healthy Families program. CHDP is a logical point of entry for the target population to be served for many reasons:

- Targeted low income children eligible under Title XXI currently access preventive health services offered through CHDP;
- CHDP providers are likely to be providers in the HFP and serve as the medical home for children enrolled in plans; and
- Integrating CHDP as a component of Healthy Families provides the new program with acceptability and credibility for providers and families.

To assure that uninsured children in the target population move smoothly into enrollment in either the Healthy Families or Medi-Cal programs, California adopted a form of limited retroactive eligibility. Once enrolled in one of the programs, a child is provided 90 day retroactive eligibility to the date of the screening visit for payment for services related to health, dental or vision care needs identified at the initial visit. The cost of these services is reimbursed on a fee for service basis (at Medi-Cal rates) during the period from application to enrollment and are paid by Title XIX for children enrolled in the Medi-Cal program and by Title XXI for children enrolled in the HFP.

California Children's Services (CCS*)*. CCS provides funding for medical care for eligible low-income families with children with serious medical problems, such as critical acute illnesses, chronic illnesses, genetic diseases, physical handicaps, major injuries due to violence and accidents, congenital defects, and neonatal and pediatric intensive care unit level conditions.

Affect on SCHIP Program Design

Integrating the CCS program into Healthy Families provided a mechanism for uninsured low income children with serious health conditions to continue to have access to a program respected by the medical community because of its focus on high quality care. Children with chronic, serious, and complex physically handicapping conditions are best served by systems and programs, which have been organized specifically to serve them. It is important that care not be disrupted and that continuity and quality of services be maintained. With these goals in mind, all plans participating in the HFP are required to refer CCS-eligible children to the CCS program for the treatment of CCS-eligible conditions pursuant to a Memorandum of Understanding (MOU) between the two organizations for CCS related services. The required MOUs formalize an arrangement between the plans and the CCS program. CCS program staff determine the appropriate source of health care for eligible children, assist families in accessing care, and identify other needs of the child and family that could impact the care of the eligible condition. CCS program staff also carefully coordinates the authorization and delivery of specialty and subspecialty services with the primary care provider to whom the child is assigned. No copayments are charged for CCS services, families with children with severe health conditions are protected from the burden of copayments.

County Mental Health Service

Affect on SCHIP Program Design

A basic benefit package is provided by the health care plans. This includes 20 outpatient visits, and 30 inpatient mental health days per year. Children with serious emotional disturbances (estimated at between 3-5% of the general population) are referred by the health care plan to the county mental health program for treatment, pursuant to a Memorandum of Understanding (MOU) between the two organizations for any needed additional mental health services. The required MOUs formalize this important arrangement. The county mental health program coordinates the delivery of mental health and other health services with the health care plan for those children who meet the criteria of serious emotional disturbance. County mental health programs provide mental health treatment services directly or through contracts with private organizations and individual providers. The requirements for provider selection and quality improvement for these mental health services are consistent with those used for the Medi-Cal program with a similar population.

Major Risk Medical Insurance Program (MRMIP). MRMIP provides state subsidized health coverage to individuals, including children, who are denied coverage by private carriers because of a pre-existing medical condition. People who are eligible for Medicaid or Medicare cannot enroll in this program. Approximately 6% of the program subscribers are children.

Affect on SCHIP Program Design

Many of the "lessons learned" through the development of this program have been incorporated into the Healthy Families Program.

AIM. The AIM program is a public-private partnership which offers creditable coverage to pregnant women with incomes between 200 percent and 300 percent of FPL and their newborn children through the first two years of life. AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the full cost of care, California uses Proposition 99 tobacco tax monies to subsidize subscriber copayments and contributions, while the subscriber pays a participation fee equal to two percent of their average annual income.

Affect on SCHIP Program Design

The AIM program uses some Title XXI funding. For FFY99, payments to AIM health plans were budgeted at $5.1 million

California Health Care for Indigents Program provides funding to large counties for uncompensated hospital, physician, and other health service costs. To be eligible for SCHIP funds, counties must meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

Affect on SCHIP Program Design

None

Rural Health Services (RHS). RHS provides funding to small rural counties for uncompensated hospital, physician, and other health services costs. To be eligible, counties must participate in the County Medical Services Program, meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment

for children with health problems and/or medical disorders detected through the CHDP program. The program contracts with the State Office of County Health Services for the rural counties obligation to provide follow-up treatment for conditions identified in CHDP screens.

Affect on SCHIP Program Design

None on the original design. RHS services staff have been trained as CAAs and are making an effort to enroll children in HFP/MCC.

Expanded Access to Primary Care (EAPC). EAPC provides financial assistance to primary care clinics serving medically-under served areas or populations. EAPC is funded through Proposition 99 tobacco tax monies and serves individuals at or below 200 percent of the poverty level on a sliding scale basis.

Affect on SCHIP Program Design

None

Seasonal Agricultural and Migratory Workers Health Program. This program provides financial and technical assistance to primary care clinics serving the needs of seasonal, agricultural, and migratory workers and their families. Individuals pay on a sliding scale.

Affect on SCHIP Program Design

None on original design. Primary care clinics coordinate with the HFP's Rural Health Demonstration Project to provide access to services for this target population.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened that program?

___ *No pre-existing programs were "State-only"*

_X__ *One or more pre-existing programs were "State only"*

Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

The following programs are "State Only". Please refer to Table 2.2.2 to review current status on enrollment, target groups and consolidation into SCHIP

Program Name	Enrollment Status	Target Group	Folded into SCHIP Y/N
Rural Health Services (RHS)	Still Enrolling	Children referred through CHDP. Funding to small rural counties that provide service to target population	N
Expanded Access to Primary Care (EAPC)	Still Enrolling	Individuals below 200% FPL Funding to primary care clinics who provide services to target population	N
Seasonal Agricultural and Migratory Workers Health Program	Still Enrolling	Migratory workers and families. Funding to primary care clinics that provide services to target population	N
Access for Infants and Mothers (AIM)	Still Enrolling	Pregnant women with incomes between 200% and 300% of FPL and their newborn children through the first two years of life	Y

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

_X__ ***Changes to the Medicaid program***

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
_X__ Provision of continuous coverage (specify number of months.
Provision of one month of continuous eligibility to be used by families who no longer qualify for no share-of-cost Medi-Cal to transition to the Healthy Families Program.

_X__ Elimination of assets tests
Disregard resources of the parent and child, for children between 1-19 in the Federal Poverty Programs, thereby expanding coverage under Title XXI for children whose families meet Medi-Cal's income standards but have not met its resource requirements.

_X__ Elimination of face-to-face eligibility interviews
Face-to-face eligibility reviews are no longer required for HFP/MCC applicants.

_X__ Easing of documentation requirements.
The documentation requirements for income include a minimum of one pay stub, a signed statement from employer or tax return. For the self employed, a Federal Tax 1040 or current profit & loss statement is required. For applicants, a yearly Federal Tax 1040 can be averaged to a monthly basis, eliminating the need for monthly verification.

The easing of documentation requirements and face-to-face eligibility requirements are due to the implementation of the joint HFP/MCC application. Data collection and processing allows a method of identifying and routing prospective MCC participants to the MCC program. The process is called *"Single Point of Entry***"** and has been successful in directing eligible participants to California's Medi-Cal program. The State implemented this process in March 1999 and has directed approximately ***25,000*** applications to Medi-Cal through 9/30/99. This represented approximately 25% of the total single point of entry applicants during this period.

_X__ ***Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF***

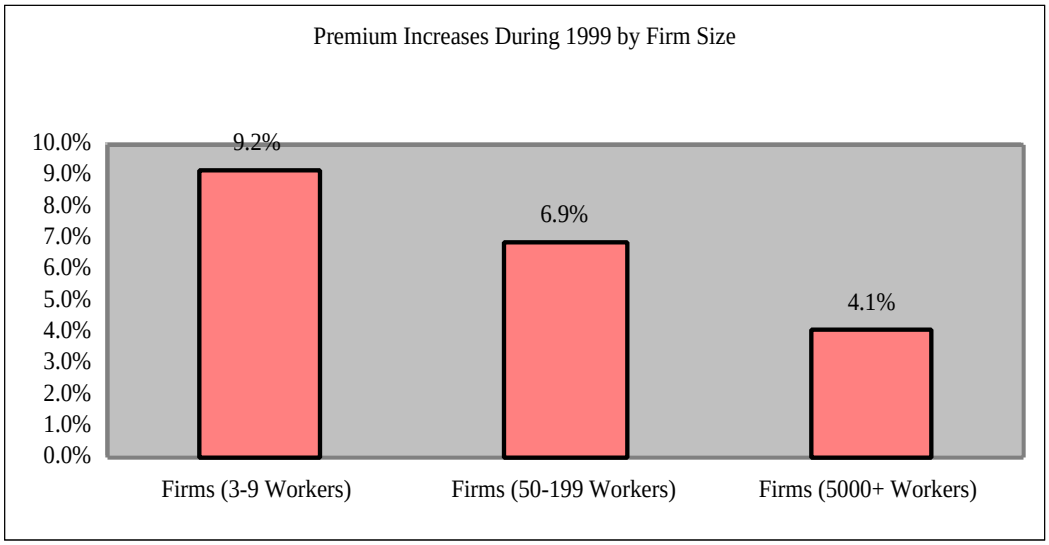
A critical barrier to enrollment for both HFP and MCC was ambiguity in the federal policy on immigration issues of "public charge" and sponsorship. Many parents who are not citizens but have legal alien and citizen children will not enroll them into the HFP or MCC until they are assured the receipt of health benefits will not jeopardize their immigration status. These concerns are relevant to a significant percentage of the HFP/MCC eligible populations.

Following release of the May 1999 guidance from the Immigration and Naturalization Service (INS), MRMIB has made significant efforts to clarify federal policy to applicants through the network of Community Based Organizations. These efforts included targeted outreach letters to enrolled entities specifically addressing this issue.

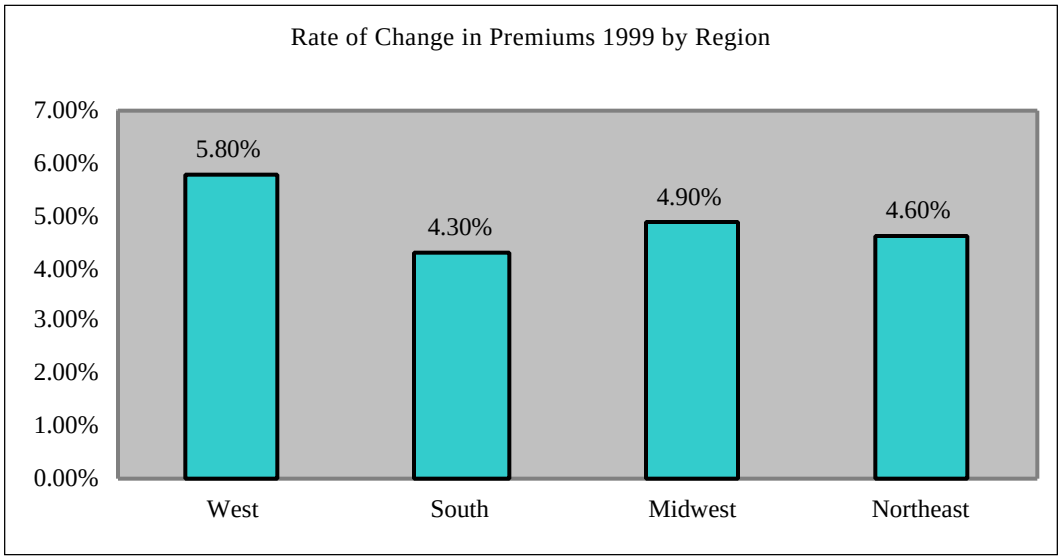
X__ ***Changes in the private insurance market that could affect affordability of or accessibility to private health insurance.***

X_ Health insurance premium rate increases

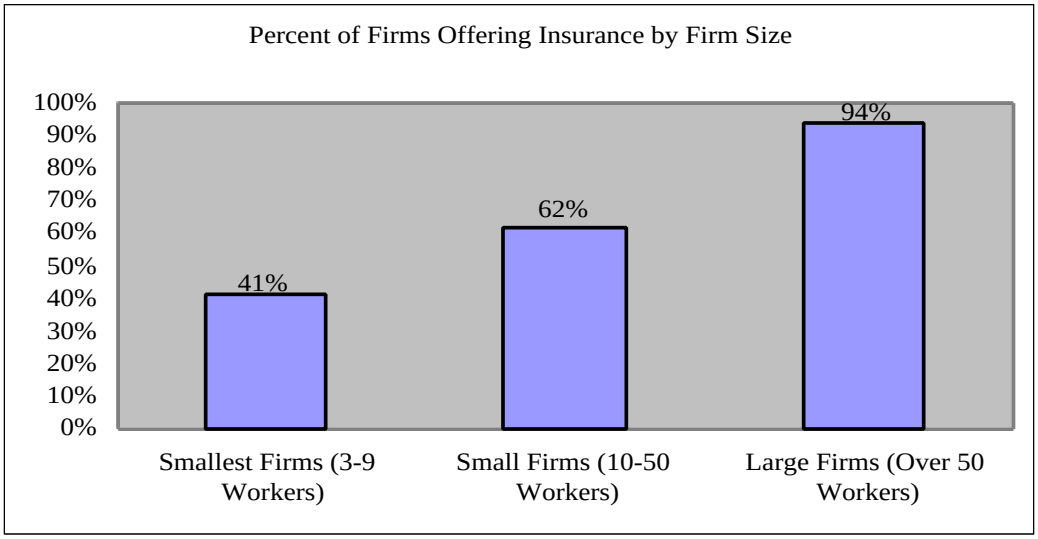
The Kaiser/HRET study found that health insurance premiums increased approximately 4.8% from July 1998 to the end of the reporting period 9/30/99. This is a significant increase when compared to increases in worker's earnings of 3.5% and the medical care component of the Consumer Price Index of 3.4%. The following graph represents the rise in premiums by firm size. Small firms experienced the highest premium increases.



On a regional level, premiums in the West rose 5.8% in the previous year compared to 4.3% in the South, 4.9% in the Midwest, and 4.6% in the Northeast.



In 1999, 48% of California's employers provided health coverage to employees in contrast with 61% of employers nationally. California's rate differed depending on firm size.



___ ***Legal or regulatory changes related to insurance***

___ ***Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)***

__***X***_ ***Changes in employee cost-sharing for insurance***

According to the Kaiser/HRET study, Californians pay less for their coverage than elsewhere in the nation: In California, the average employee's monthly contribution was $21/month (11% of premium) for single coverage and $117/month (24% of premium) for family coverage. Nationally, contributions averaged $35/month (16% of premium) for single coverage and $145/month (32% of premium) for family coverage.

___ ***Availability of subsidies for adult coverage***

___ ***Other (specify) _____***

___ ***Changes in the delivery system***

___ ***Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)***

___ ***Changes in hospital marketplace (e.g., closure, conversion, merger)***

___ ***Other (specify) _____***

___ ***Development of new health care programs or services for targeted low-income children (specify)***

__X_ Changes in the demographic or socioeconomic context

__X Changes in population characteristics, such as racial/ethnic mix or immigrant status.

Population / Racial & Ethnic Mix

According to the California Department of Finance, California's fiscal year 1996-97 population growth rate of 1.8 percent was nearly double the 1995-96 growth rate of 1.0 percent and was almost as high as the 1990-91 and 1991-92 levels. All five race/ethnic categories increased in their growth rates during 1996-97. From the 1990 census to July 1997, California added 3,198,700 new residents.

The race/ethnic distribution in California shifted during the 1990's from White to Hispanic and Asian and Pacific Islander. Since the 1990 census, California's White population declined from 57 to 53 percent by July 1997. By contrast, the Hispanic population increased from 26 to 29 percent during the same period. Similarly, the Asian and Pacific Islander population increased from 9 to 11 percent. Growth in the Hispanic and the Asian and Pacific Islander populations accounted for 89 percent of California's population increase. The proportion of the Black and Native American populations remained unchanged at 7 percent and 1 percent, respectively.

Since 1990, 53 percent (1,681,500) of the population growth in California resulted from Hispanic natural increase (births minus deaths). Hispanic natural increase averaged 232,400 per year from July 1990 to July 1997. Net migration added 270,200 Hispanic residents from the 1990 census to July 1997.

The major increase in the Asian and Pacific Islander population came from migration (62 percent). Just over 545,000 Asian and Pacific Islanders immigrated to California between the 1990 census and July 1997, 89 percent of the total net migration of 611,600 during this period. Asian and Pacific Islander net migration averaged 74,300 per year from July 1990 to July 1997, while natural increase averaged 46,200. Asian and Pacific Islanders were the only race/ethnic group to experience a positive net migration to California for all the reported years.

From July 1992 to July 1996, White out-migration shifted the race distribution towards Hispanics and Asian and Pacific Islanders. In 1996-97, however, Whites posted a net migration gain of 68,000. California's White net migration loss averaged 38,100 per year from July 1990 to July 1997.

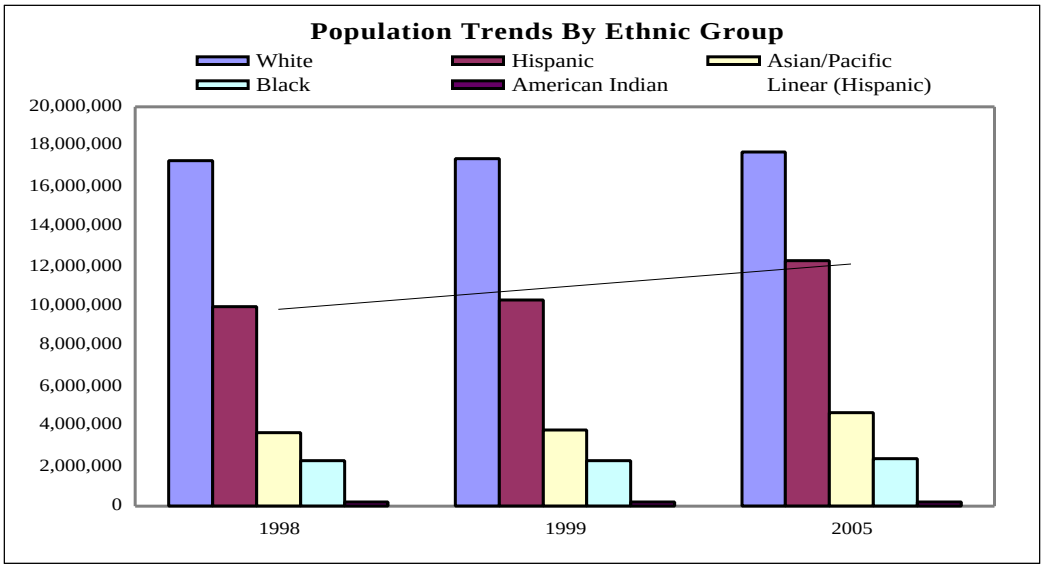
The Black population remained at 7 percent of California's population, growing about 1.4 percent annually since July 1990, with 82 percent of the growth coming from natural increase. The Native American population recorded a natural increase of 14,700 while losing 3,000 to out-migration. This resulted in a net increase of 11,700 persons between the 1990 census and July 1997.

California is projected to grow in population between 1.5% and 2% for the foreseeable future. Migration is the most volatile component of population change. Over the past 30 years, annual migration has fluctuated between –82,000 and +421,000. The California Department of Finance expects migration to return to the historic average over the next 5 years, with net yearly migration at +250,000.

The ethnic demographics forecasted through 2005 are described in the following table.

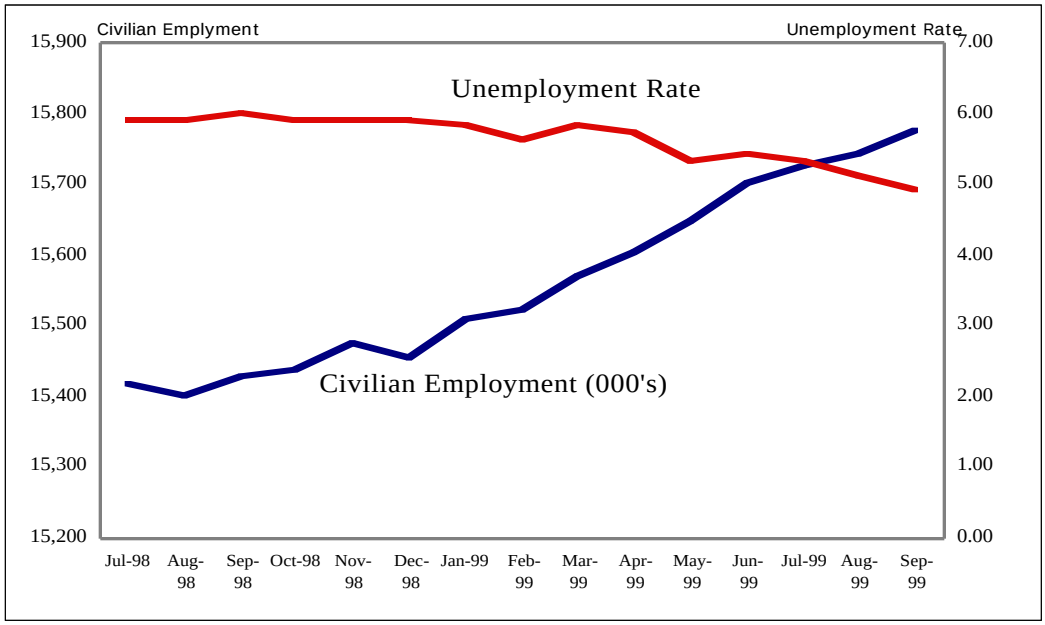
Year	Total	White	Hispanic	Asian/ & Pacific	Black	American Indian
1998	33,506,406	17,258,003	10,022,551	3,716953	2,309,052	199,747
Percent	***100%***	***51.5%***	***29.9%***	***11.1%***	***6.9%***	***.6%***
1999	34,072,478	17,339,690	10,352,763	3,856,288	2,320,916	202,821
Percent	***100%***	***50.9%***	***30.4%***	***11.3%***	***6.8%***	***.6%***
2005	37,372,444	17,731,217	12,300,819	4,684,467	2,433,988	221,953
Percent	***100%***	***47.4%***	***32.9%***	***12.5%%***	***6.5%***	***.6%***

The projected trends in the demographic mix continue to reflect reductions in the percentage of White populations being replaced by increases in Hispanic and Asian & Pacific populations. Immigration is expected to increase over the 2000 – 2005 period.



__X__ ***Changes in economic circumstances, such as unemployment rate.***

The California economy has continued to grow at a high relative rate over the past five years with the unemployment rate dropping steadily from levels above 8% during 1995 to 4.9% as of September 30, 1999. The unemployment rate on July 1998, (the implementation of Healthy Families Program), was 5.9%, with a total civilian employment of 15.4 million. At the end of the Federal Fiscal Year 1999, California's unemployment rate stood at 4.9% with total civilian employment at 15.8 million.



During the 15 month period after Healthy Families implementation to the end of the Federal Fiscal Year 1999, California has added over 335,000 jobs and reduced unemployment by a full percentage point. California's unemployment rate is currently following the national trend.

Section 3. Program Design

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed SCHIP Program**	**Other SCHIP Program* AIM**
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide	Statewide	Statewide
Age	14-19 (Asset Test Elimination –all ages)	1-18	Infants
Income (define countable income)	85% to 100% FPL to 14-19	100%-200% FPL	200% - 300% FPL
Resources (including any standards relating to spend downs and disposition of resources)	None	None	None
Residency requirements	Children must be California resident. They must also meet the citizenship and immigration status requirements applicable to Title XIX	Children must be California resident. They must also meet the citizenship and immigration status requirements applicable to Title XXI.	Must have lived in California for the last 6 months.
Disability status	None. There are no pre-existing condition exclusions	None (as long as any standard relating to disability status does nor restrict eligibility). There are no pre-existing condition exclusions	None (as long as any standard relating to disability status does not restrict eligibility). There are no pre-existing condition exclusions

Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	Children with other health coverage can still be eligible. Medi-Cal is payer of last resort	Children are ineligible if they have been covered under employer sponsored coverage within the prior 3 months or if they are eligible for (no cost) Medi-Cal or Medicare PartA or PartB coverage	Can not be receiving no-cost Medi-Cal benefits at the time of application. Cannot have maternity benefits through private insurance, if coverage has a separate maternity-only deductible or co-payment that is more than $500, may qualify
Other standards (identify and describe)		Premiums must be paid. Children are ineligible if they are within a CalPERS health benefits eligible household, or an inmate at a public correctional institution or a patient in an institution for mental health	Must be pregnant, but not more than 30 weeks pregnant at time of application

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program* AIM
Monthly			
Every six months			
Every twelve months		X	
Other (specify)	Quarterly		Once - upon application

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

_X__ *Yes* ***Which program(s)?*** Healthy Families

For how long? 12 months

___ *No*

3.1.4 Does the SCHIP program provide retroactive eligibility?

___ Yes _ Which program(s)?

How many months look-back?

_X__ No

3.1.5 Does the SCHIP program have presumptive eligibility?

___ Yes _ Which program(s)?

Which populations?

Who determines?

__X_ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

__X_ Yes _ Is the joint application used to determine eligibility for other State programs? If yes, specify. Medi-Cal for Children and Medi-Cal for Pregnant Women

___ No

3.1.7 Evaluate the strengths and weaknesses of your eligibility determination process in increasing creditable health coverage among targeted low-income children.

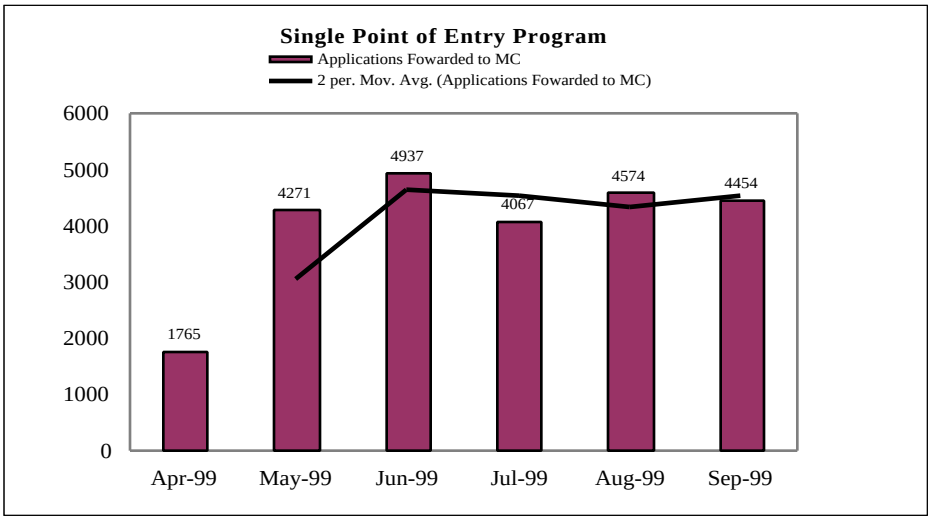
Application Length

The joint application for Medicaid and SCHIP is a simple booklet containing four pages to complete, along with three pages of instructions, guidelines, and helpful hints on completing the questions. This application was reduced from a 28 page document after review and suggestions from stakeholders.

Application Assistance

Many applications are completed with the help of a "Certified Application Assistant" who guides the applicant through the process. These assistants are located throughout the State. Enrolled Entities (EE's) are paid an assistance fee ($50) for each successful application. This service is free to the applicant. A toll-free number is also available where applicants can receive application assistance, instructions and locations of "Certified Application Assistants". In addition, a HFP help line is available for application, billing and other administrative services. Program information are available online at *www.healthyfamilies.ca.gov* or *www.mrmib.ca.gov*.

Single Point Of Entry
The Healthy Families Program's application data collection and processing allows a method of identifying and routing prospective Medicaid participants to the Medicaid program.

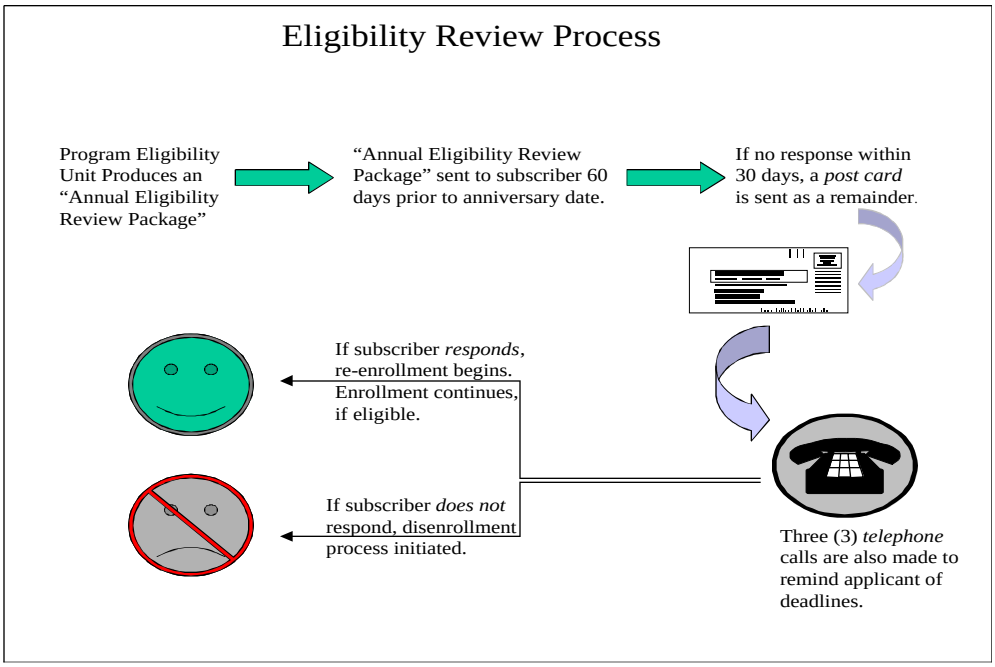


The process is called *"Single Point of Entry***"** and has been successful in directing eligible participants to California's Medi-Cal program. The State implemented this process in March 1999 and has directed approximately *25,000* applications to Medi-Cal through 9/30/99. This represented approximately 25% of the total single point of entry applicants during this period.

Based on the enrollment trends attributable to single point of entry, it can be forecast that a significant number of Medi-Cal eligible children will be enrolled through the joint HFP/MCC outreach campaign.

Application Complexity
The application is a simple user–friendly document with each question explained in detail. Color-coding is used to delineate areas and call attention to important facts. A business reply, postage paid envelope is included as a pull out section, making for a convenient one step process. The annual eligibility review documentation is pre-printed with information specific to each applicant (such as current plan and number of children enrolled) for ease of use and modification.

Documentation Requirements
The documentation requirements for income include a minimum of one pay stub, a signed statement from employer or the most recent tax return, and income deductions. For the self employed, a Federal Tax 1040 or current profit & loss statement is required. Citizenship and immigration documentation are also required.



3.1.8 ***Evaluate the strengths and weaknesses of your eligibility redetermination process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?***

The annual eligibility review process for HFP involves contact with the enrollee through mailed pre-printed correspondence. A two page Annual Eligibility Review Package (AER) is sent for completion and return to the Healthy Families Program Administrative Vendor. Cards and telephone calls are utilized as follow up notification for the subscriber. Post cards stating the effective date of disenrollment are utilized as a second time contact. If there is no response from the enrollee, the program attempts to contact the enrollee by telephone three times. If there is no response within the eligibility review period, the enrollee is disenrolled from the program.

Customer Service: The annual eligibility review process is designed to allow an easy and seamless transition to the next benefit year. The Annual Eligibility Review Package (AER) concept allows for a long lead-time (60 days) in reaching enrollees and provides a convenient pre-printed turnaround document for their submission. During the 4th quarter of FFY 1999, 7,833 packets were sent to families and 7,141 responded. This represents a 91% response rate. Of those who responded, 80% remained eligible.

Calls are made to applicants and enrollees to request the return of the required documentation and complete the package. If no response is received after 30 days, an automated reminder postcard is sent to the family.

Single Point of Entry: The system is programmed to screen for no-cost Medi-Cal eligibility. The built-in algorithms provide an efficient and accurate method for routing applicants to appropriate programs. In addition, it allows for a streamlined "audit trail" for current and closed cases.

Systems Administration: The administrative vendor has structured the annual eligibility review process to allow access to information from the initial eligibility application. This eliminates redundant data entry of data for faster approval times. The HFP administrative vendor, Electronic Data Systems, system also allows for computer imaging of the application along with an online note/comment module to help guide personnel through the application/annual eligibility review process.

Differences in the determination and redetermination process.
The following table describes the differences between eligibility determination and annual redetermination.

Major Areas	**Determination**	**Redetermination** (Annual Eligibility Review)
Application	The application is a simple four (4) page document, providing initial participant data	The AER is a two (2) page document requesting the applicant to provide changes in family size and income documentation that may have occurred during the prior 12 months
Documentation	Pay Stubs, signed letter from employer to verify income, or Federal tax return or current Profit and Loss Statement	Same as Determination
Timing	10 days to determine eligibility of a complete application, which includes a single point of entry determination (4 days). An additional 10 days is required by the health plans to process, enroll, and provide subscriber with required ID cards and packets	Same as Determination Except no new ID cards are sent. If applicant responds in a timely manner, there is no break in coverage and no addition time for health plan processing
Eligibility	See table 3.1.1 for eligibility	Same as determination. Adding a child will change the anniversary date to the date the last child was enrolled
Approval	Administrative vendor uses "Eligibility Enrollment Specialists" to review and approve initial eligibility and screen for Medi-Cal eligibility. This process reviews and verifies all data provided on the initial application. Approval is provided when all eligibility requirements are satisfied. A "welcome call" is made after approval to assure applicants receive plan information	Administrative vendor utilizes a separate group of specialists to perform an abbreviated review and approval of changes submitted on the Annual Eligibility Review Package. Approval is provided when all eligibility requirements are satisfied

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

Table 3.2.1 CHIP Program Type **Healthy Families Program State CHIP Program**			
Benefit * Note: Services provided to children with special needs through CCS and CMH are provided at no cost.	Is Service Covered? Y = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify) ALL SERVICES MUST BE MEDICALLY NECESSARY
Inpatient hospital services	Y	None	No
Emergency hospital services	Y	$5/Copay/Waived when it patient is admitted.	No
Outpatient hospital services	Y	$5/Copay	No
Physician services	Y	$5/Copay No copay if service provided in an inpatient setting.	No
Clinic services	Y	$5/Copay	No
Prescription drugs	Y	$5/Copay unless provided in inpatient setting.	No
Over-the-counter medications	Y	No copay for FDA approved contraceptive drugs and devices.	No
Outpatient laboratory and radiology services	Y	None	No
Prenatal care	Y	None	No
Family planning services	Y	None	No
Inpatient mental health services	Y	None	30 Days
Outpatient mental health services	Y	$5/Copay	20 Visits per Benefit Year
Inpatient substance abuse treatment services	Y	None	No
Residential substance abuse treatment services	N		
Outpatient substance abuse treatment services	Y	$5/Copay	20 Visits per Benefit Year
Durable medical equipment	Y	None	No
Disposable medical supplies	N		No
Preventive dental services	Y	None	No
Restorative dental services	Y	No copay except micro-filled resin restorations	No
Hearing screening	Y	None	No
Hearing aids	Y	None	No

Vision screening	Y	None	No
Corrective lenses (including eyeglasses)	Y	$5/Copay	No
Developmental assessment	Y	None	No
Immunizations	Y	None	No
Well-baby visits	Y	None	No
Well-child visits	Y	None	No
Physical therapy	Y	$5/Copay if done as outpatient. No copay if done as inpatient.	60 Consecutive Calendar Days
Speech therapy	Y	$5/Copay if done as outpatient. No copay if done as inpatient.	60 Consecutive Calendar Days
Occupational therapy	Y	$5/Copay if done as outpatient. No copay if done as inpatient.	60 Consecutive Calendar Days
Physical rehabilitation services	Y	$5/Copay if done as outpatient. No copay if done as inpatient.	No
Podiatric services	Y	$5/Copay/Outpatient only	No
Chiropractic services	Y	$5/Copay	20
Medical transportation	Y	None	No
Home health services	Y	No copay except for home visits for physical, occupational, or speech therapy.	No
Nursing facility	Y	None	No
ICF/MR	N		
Hospice care	Y	None	No
Private duty nursing	N		
Personal care services	N		
Habilitative services	N		
Case management/Care coordination	Y	None	
Non-emergency transportation	Y	None	No
Interpreter services	Y		No
Acupuncture			20 Visits per Benefit Year
Other (Specify)			
Other (Specify)			

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

California has a comprehensive, coordinated benefit package for its Healthy Families enrollees. The central component is the health plan benefits under the benchmark coverage, the State employee benefit package. The benchmark plan is augmented with comprehensive dental and vision benefits. Furthermore, the coordinated benefit package includes screening and initial treatment services provided through the CHDP program. Services needed by special needs children are provided through a specialized delivery system under the CCS program. Mental health services for severely emotionally disturbed children are provided through county mental health departments through referral and coordination with health plans.

Please highlight the level of preventive services offered and services available to children with special health care needs.

Child Health and Disability Prevention Program (CHDP)
To maximize access, continuity of care, and ease of administration, the CHDP program which provides preventive health screening examinations for children with family incomes of less than 200 percent of the federal poverty level is integrated into the design of the Healthy Families Program. CHDP is a logical point of entry for the target population to be served for many reasons:

- Targeted low income children eligible under Title XXI currently access preventative health services offered through CHDP;
- CHDP providers are likely to be the providers in the child health insurance plans and serve as the medical home for children enrolled in plans; and
- Integrating CHDP as a component of Healthy Families provides the new program with acceptability and credibility for providers and families.

To assure that uninsured children in the target population move smoothly into enrollment in either the Healthy Families or Medi-Cal programs, California adopted a form of limited retroactive eligibility. Once enrolled in one of these programs, a child is provided 90 day retroactive eligibility to the date of the screening visit for payment for services related to health, dental or vision care needs identified at the initial visit. The cost of these services is reimbursed on a fee for service basis (at Medi-Cal rates) during the period from application to enrollment. The services provided during this period of retroactive eligibility are specified in regulation. Appropriate referral is also made to the CCS program if the problem identified through the screening examination appears to be a CCS

eligible condition. To ensure continuity of care whenever possible, referrals for treatment services are made to providers in the Healthy Families Program that the family has chosen. During the period between application and enrollment, the county CHDP Program can assist with identification of providers, scheduling appointments for identified health care needs, coordination of services and completion of the application form.

Mental Health
A basic benefit package is provided by the health care plans. This package includes 20 outpatient visits and 30 inpatient mental health days per year. While it is anticipated that the mental health needs of most children can be met under the benefit package, it is recognized that some seriously emotionally disturbed children will require more specialized mental health services. Consistent with the treatment of similarly situated privately insured populations, these children are eligible for specialized mental health services through the county mental health system of care.

Children with serious emotional disturbances (estimated at between 3%-5% of the general population) are referred by the HFP participating plans to the county mental health program for treatment, pursuant to a Memorandum of Understanding (MOU) between the two organizations. The required MOU formalizes this important arrangement. The county mental health program coordinates the delivery of mental health and other health services with the health care plan for those children who meet the criteria of serious emotional disturbance. County mental health programs provide the following services:

Outpatient Services	Inpatient	Partial Hospital	Prescription Drugs
Mental Health Services	Psychiatric Inpatient	Crisis Residential	Provided under
Day Treatment Services	Psychiatric Facility	Psychiatric Facility	Medical Support
Day Rehabilitation Services			Services
Crisis Intervention			
Crisis Stabilization			
Medication Support Services			

California Children's Services(CCS) Program
Integrating the CCS program into the Healthy Families Program is a logical way to ensure that uninsured low income children with serious health conditions will have access to a program respected by the medical community because of its focus on quality care. Children with chronic, serious, and complex physically handicapping conditions are best served by systems and programs that have been organized specifically to serve them. It is important that care not be disrupted and that continuity and quality of services be maintained. With these goals in mind, plans are required to refer CCS-eligible children to the CCS program for the treatment of CCS-eligible conditions.

CCS, the Title V designated program for children with special health care needs, provides medical case management and payment of health care services for those children with eligible medical conditions who live in families with annual incomes below the program's income eligibility. In July 1999, California State law was amended to assure

all children eligible for HFP are deemed income eligible for CCS. CCS coverage is limited to coverage of specific conditions.

The program establishes standards for approval of inpatient hospital facilities and pediatric specialty and subspecialty providers delivering care to eligible children. The program also has an extensive system of special care centers located at tertiary medical centers at which multispecialty, multidisciplinary teams deliver coordinated inpatient and outpatient care to children with chronic medical conditions. The centers include cardiac, chronic pulmonary disease, hematology and oncology, myelomeningocele, hemophisia, sickle cell, renal, infectious disease/immunology, hearing and speech, metabolic disorders, inherited neurologic disease, limb defect, gastroenterology, craniofacial anomalies and endocrinology. The CCS program also approves neonatal intensive care, pediatric intensive care, and pediatric rehabilitation units. Transportation and maintenance (e.g., lodging, meals) that are not available through the health plans, are provided through CCS for families that need to use special care centers outside their area.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program (CA Medi-CalProgram)	State-designed CHIP Program	Other CHIP Program* AIM
A. Comprehensive risk managed care organizations (MCOs)		Yes	Yes
Statewide?	_X_ Yes ___ No	_X_ Yes ___ No	_X__ Yes ___ No
Mandatory enrollment?	_X__ Yes __ No	___ Yes _X_ No	___ Yes __X_ No
Number of MCOs	26	25	9
B. Primary care case management (PCCM) program		No	No
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	Dental	Dental Vision	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	Yes via CCS, CMH	Yes via CCS, CMH	No
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

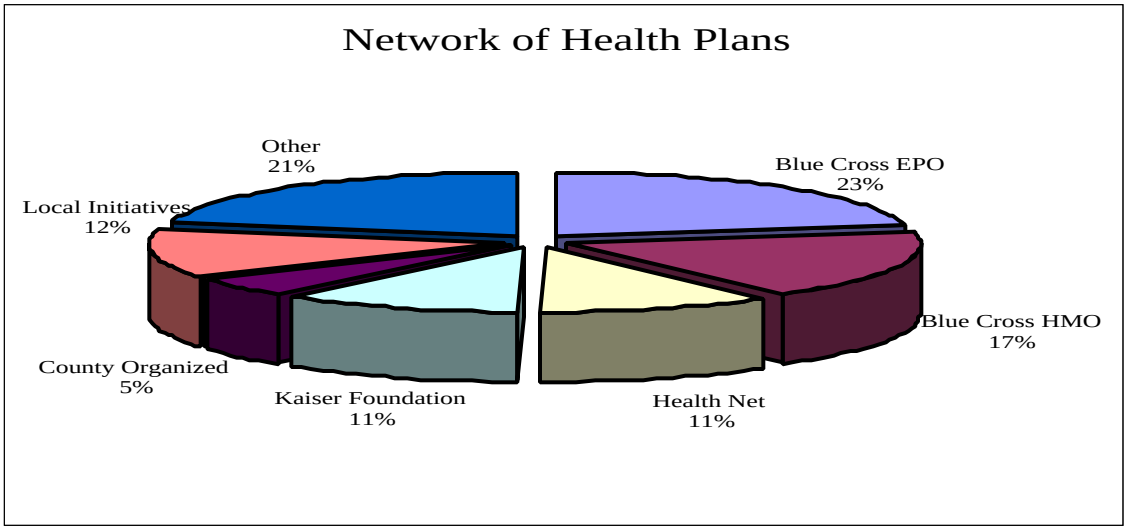
California's approach is to serve targeted low income children through an integrated system of care. The central component of this system is the Healthy Families Program to provide creditable health, dental and vision insurance coverage through managed care organizations. MRMIB uses insurance purchasing pool mechanisms to provide managed care to targeted low-income children between ages 1 through 18.

Healthy Families Purchasing Pool
Through the *purchasing pool,* the State delivers a comprehensive range of health services to targeted low income children. The State uses the power of pooled purchasing not only to obtain affordable coverage for uninsured children but also to demand high quality services for children. For the majority of eligible families, MRMIB offers access to health plans through a subsidized consumer choice purchasing system.

The pool is built around the concepts used successfully by organized purchasers such as the California Public Employees Retirement System (CalPERS) and Pacific Business Group on Health (PBGH) -- price competition among managed care health plans, family choice of plans, performance based contracts with plans, and reliance on existing private sector delivery systems.

In the HFP pool, some of the same health plans and networks available in the employer market are available to beneficiaries, providing broad access to health care providers. Most of the plans participating are health maintenance organizations (HMOs), however one preferred provider organization (PPO) participates. PPOs participate in several of MRMIB's programs and are a particularly effective means of providing coverage in areas with little or no penetration by HMOs.

MCO Network
MRMIB contracts with 25 health care organizations. They represent a wide breadth of MCOs ranging from nationwide HMOs to smaller local initiatives that target specific areas within California. All counties and zip codes are served by at least one organization.



As shown on the above chart, the HFP contracts with some of the largest HMOs in the California as well as the country. The plan with the most enrollees is Blue Cross EPO with over 45,000 HFP enrollees. The smallest plan covers less than 500 HFP enrollees, while the others cover approximately 4,000 enrollees.

Communication
MRMIB purchases health insurance through the above MCOs. Systems of communication and coordination have been established to assure that quality services are provided to HFP enrollees at the best possible price.

Contracts are updated with new state and federal requirements on an annual basis. Any modifications to the contracts are communicated to plans that are competing for the HFP business.

Annual Contracting, Bidding and Plan Selection Process
The annual contracting process requires the MCOs to offer their best price, certifying compliance with all requirements of MRMIB, and offer coverage to licensed geographical areas. The MRMIB compiles all bid applications that meet the required regulatory and coverage areas. After all bids are compiled, the average price of the lowest two (2) plans plus ten percent (10%) set the benchmark for pricing. Any bidder not willing to match this price is eliminated.

Steps in Contracting, Bidding and Plan Selection Process

1 - Contract modified from prior year.

2 – Model Contract and Proposal Solicitation issued.

3 - Proposals received and analyzed for compliance
Terms reviewed -> Networks analyzed - > Special Reports analyzed.

4 - Bid calculation to determine benchmark for each geographical region.

5 - Pricing feedback presented to bidders.

6 – Second round of pricing from plans.

7 - Participating plans chosen. Contracts finalized.

8 - Open enrollment begins.

.

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

_X__ *Yes, check all that apply in Table 3.3.1*

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* AIM Access for Infants and Mothers
Premiums		X	
Enrollment fee			
Deductibles			
Coinsurance/copayments**		X	
Other (specify) Cost – 2% of Annual Family Income			X

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Healthy Families Program Premiums

The monthly premium charge for families *below* 150% FPL ranges from $4 to $7 per child per month (with a maximum contribution of $14 per family per month).

The following table illustrates the premium expense for a full range of income and family size for families between 100% and 150% of FPL

Family Size	Qualifying Monthly Income	Monthly Family Premium
1	$ 687.01 to $1,030	$4 to $7
2	$ 922.01 to $1,383	$4 to $7
3	$ 1,157.01 to $1,735	$4 to $14
4	$ 1,392.01 to $2,088	$8 to $14
5	$ 1,627.01 to $2,440	$8 to $14
6	$1,862.01 to $2,793	$8 to $14
7	$ 2,097.01 to $3,145	$8 to $14
8	$ 2,332.01 to $3,498	$8 to $14
9	$ 2,567.01 to $3,850	$8 to $14
10	$2,802.01 to $4,203	$8 to $14

The monthly premium charge for families *above* 150% FPL ranges from $6 to $9 per child per month (with a maximum contribution of $27 per family per month).

The following table illustrates the premium expense for a full range of income and family size for families between 150% and 200% of FPL.

Family Size	Qualifying Monthly Income	Monthly Family Premium
1	$ 1,030.01 to $1,373	$6 to $9
2	$ 1,383.01 to $1,834	$6 to $9
3	$ 1,735.01 to $2,313	$6 to $18
4	$ 2,088.01 to $2,783	$12 to $27
5	$ 2,440.01 to $3,253	$18 to $27
6	$ 2,793.01 to $3,723	$18 to $27
7	$ 3,145.01 to $4,193	$18 to $27
8	$ 3,498.01 to $4,663	$18 to $27
9	$ 3,850.01 to $5,133	$18 to $27
10	$4,203.01 to $5,603	$18 to $27

Premium ranges shown in the tables reflect discounted premiums that are charged for Community Provider Plans.

The health plan in each county with the highest percentage of traditional and safety net providers in its network is designated as a Community Provider Plan (CPP) and is offered at a $3 per child monthly premium discount. *(See previous table for premiums).*

Failure to pay premium and lock out period
When payments are 60 days late, subscribers are no longer eligible for coverage in the program. The child's coverage ends as of the last month for which the premium was paid in full. If the child's coverage is terminated because of non-payment, the child is not able to participate in the program for six months. In certain situations the rule will be waived. They include: illness that resulted in being unable to work for two weeks, applicant's loss of job, child qualified for no-cost Medi-Cal, or failure to return Annual Eligibility Review documents before the end of the 12 month eligibility period.

Innovative methods to premium collection
Subscriber's personal check, cashiers check, money order, credit card, electronic funds transfer, or cash are acceptable ways to pay the premiums. A toll-free 800 number is available to participants to inquire about pay station locations that accept cash. An advance payment discount is available to participants. If the participant pays for three (3) month's premium in advance, they receive one (1) month free.

3.3.3 If premiums are charged: Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ ***Employer***
_X_ ***Family***
_X_ ***Absent parent***
___ ***Private donations/sponsorship***
___ ***Other (specify)***

3.3.4 If enrollment fee is charged: What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?
No enrollment fees are charged.

3.3.5 If deductibles are charged: What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?
No deductibles apply.

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

The program application is augmented with the "Healthy Families Handbook". The handbook explains the income levels for determining the monthly premium, co-payments, and the timing of payment. The family is notified through this handbook of a $250 maximum co-payment amount per benefit year. There are no health plan copayments for preventive services and a $5 copayment for non-preventative services

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ ***Shoebox method (families save records documenting cumulative level of cost sharing)***
___ ***Health plan administration (health plans track cumulative level of cost sharing)***
___ ***Audit and reconciliation (State performs audit of utilization and cost sharing)***
__X_ ***Other Mathematically not possible for a family above 150% FPL to reach 5% of family income in copays/premiums.***

In some health plans, the plan tracks the families' copayments and notifies the family when the maximum is reached. In most health plans, the participant is requested to retain all receipts for copayments made at time of service for the benefit year. California's benefit year is July 1st through June 30th. If the family reaches the maximum of $250, they are requested to notify their health plan. The health plan will not request a copayment until the next benefit year.

Because children with chronic illness are referred to the CCS and County Mental Health for care, these families are not at risk for reaching the $250 copayment maximum.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

California ensures that the annual aggregate cost sharing for a family does not exceed 5% of a family's income as required by Title XXI. With the limit of $250 for annual health benefit copayments, based on the payment formula, it is mathematically impossible for subscribers to exceed the 5% income cap. The following tables illustrate that the maximum cost sharing for a family at **150% of FPL** falls well within the 5% annual cap.

Children	Annual Income of a Single Parent Family at 150% FPL	Maximum Annual Premium Contribution	Maximum Yearly Family Contribution (Premiums+$250 in Copays)	5% Contribution of a Family at 150% FPL
1	$15,915	$108	$358	$795
2	$19,995	$216	$466	$995
3+	$24,075	$324	$574	$1,203

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

Post enrollment surveys conducted with enrollees discontinuing the Healthy Families Program have shown that premiums are not a factor in disenrollment.

The Healthy Families Program is advertised and promoted as a low cost alternative for working families. It is perceived as being "de-linked" from welfare by a large segment of the eligible population. Many participants perceive Medi-Cal with a negative stigma. This perception has led some families that are eligible for but not enrolled in Medi-Cal to prefer the HFP to avoid the stigma of welfare even though they are required to pay premiums.

3.4 How do you reach and inform potential enrollees?

The Healthy Families Program uses a combination of community based *outreach* and *education* activities to reach and inform potential enrollees of the Healthy Families Program and Medi-Cal for Children (HFP/MCC)

The ***outreach*** component of the campaign includes community-based outreach activities, such as training and support for Enrollment Entities (EEs) and Certified Application Assistants (CAAs), EE reimbursement payments, toll-free information services for applicants, CAAs, school outreach, and funds for mini-contracts with CBOs.

The ***education*** efforts includes multilingual advertising, public relations activities, media relations, partnerships with private industries and public agencies, and collateral marketing materials to promote HFP/MCC.

3.4.1 What client education and outreach approaches does your CHIP program use?

Outreach

Community Based Organizations – "CBOs" / Enrolled Entities – "*EEs*"
CBOs play an important role in providing information to potential applicants about changes in the Medi-Cal Program, the HFP, and in helping them apply for these programs. Community or government-sponsored groups can become an EE if they demonstrate that their organization has a history of providing services to the target population. EEs or their employees can attend a training session and become Certified Application Assistants (CAAs). EEs can receive reimbursement from the State for the assistance they provide in helping children and pregnant women successfully enroll in HFP or Medi-Cal. CAAs are responsible for:

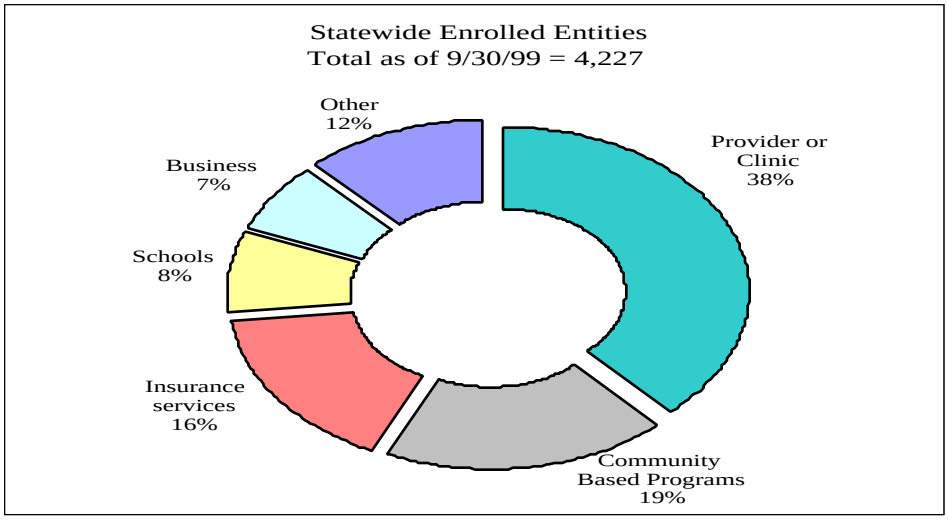
- Assisting the applicant in properly completing the application
- Conducting individual or group sessions for the purpose of assisting and educating applicants
- Answering questions pertaining to the application
- Reviewing and explaining the types of documentation to be submitted with the application
- Helping applicants learn to use the Healthy Families Handbook to find a health, dental, and vision plan
- Ensuring that they have the language capability to serve the target population
- Helping to calculate the monthly HFP insurance premium

Application Assistance Fees
A $50 fee is paid to EEs for each successfully enrolled HFP or Medi-Cal application that includes a request for fee payment. The application assistance fees are designed to encourage participation by a broad range of community organizations in outreach activities. The use of an assistance fee was adopted with the belief that, in order to reach the over 1 million eligible but uninsured children, many and varied community partners were needed.

Over *4,200* EEs and more than *17,000* trained CAAs have been recruited from program implementation in July 1998 to September 30, 1999. Participating EEs include:

- private physicians and clinics
- government agencies
- insurance agencies
- schools tax preparers
- hospitals
- faith-based organizations

About half of the applications received were completed by families without assistance from a CAA.



Contracting with CBOs

During the first year of HFP/MCC, emphasis was on training CBOs on the mail-in application and providing them with support for their outreach and enrollment activities. After the initial phase of program implementation, the additional component of contracting directly with CBOs was added in order to enhance a community education and outreach campaign. This component, mini-contracts totaling $1 million (a maximum of $50,000 per contractor), were awarded effective March 1, 1999. CBO's use these funds to enhance existing outreach activities and reach the target population by focusing on one or more of the following areas:

- Language: method(s) to address range of language needs within the community
- Culture: method(s) to address specific cultural community needs
- Geography: innovative outreach methods for rural communities, including undeserved communities and those with transportation limitations
- Innovation: methods to innovatively increase outreach and education
- Training: methods to adapt training to cultural diversity of the community
- Maintenance: teaching the benefits of preventive health care
- Grass roots involvement in outreach and education
- Increased coordination and collaborative efforts
- Special populations: migrant families/farm workers, American Indians, homeless

School Outreach

Schools provide many opportunities for outreach through existing services such as the school lunch program. They may also offer health services through a school based clinic, visiting nurse, school nurse, or counselor. The resources provide an opportunity to inform families about health insurance and HFP/MCC.

The DHS Comprehensive School Health Program developed a School Outreach Plan. Because of California's large school-aged population (5.6 million students in public schools), extensive number of school districts (999) and vast number of schools (7,800), a systems approach to reaching school-affiliated groups was chosen as being most effective.

The School Outreach Plan was designed to target leadership in state-level school-affiliated associations, organizations and agencies to actively promote HFP/MCC to their membership. Their membership, in turn, encourages enrollment of eligible families. This approach allows for the needed flexibility, which is necessary, given that California's schools are locally controlled.

In carrying out the School Outreach Plan, the California School Health Program met with key stakeholders to implement the strategies identified to promote HFP/MCC to the target groups. Examples of the key stakeholders include:

- Selected CDE programs such as Healthy Start, Child Nutrition Programs, Title I Schools, Head Start, Migrant Head Start, Indian Head Start and Early Head Start, and CDE subsidized child care centers
- California School Board Association
- California County Superintendents Educational Services Association
- Association of California School Administrators
- Parent Teachers Association
- California School Nurses Organization
- California Association of School Business Officials
- California Association of School-based and School-linked Health Programs
- School mental health practitioners via UCLA School Mental Health Project
- California Teachers Association

Direct Mailing on HFP/Medi-Cal for Children to California's Principals

In July 1998, as part of the School Outreach Plan, a direct mailing was sent to California's 7,000 principals and 1,058 superintendents. This resulted in significant action at school sites to promote and increase awareness of HFP/MCC among California's families. The mailing encouraged principals to play an important role in helping parents access affordable health care coverage by:

- including HFP enrollment information in back-to-school packets and at back-to-school nights;
- displaying HFP posters and information at schools; and
- designating staff or request others to assist in enrolling children.

The principals' packets included camera-ready promotional materials. A mechanism was set up to provide bulk copies in 10 languages for schools needing assistance in reproducing parent materials. Over **500** orders have been requested from schools/school districts throughout California. This represents over **500,000** parent information sheets.

Successful Outreach/Enrollment Strategy

- Alum Rock Union Elementary School District in Santa Clara County held its first "Healthy Families Day" event. While the goal was to provide enrollment assistance to 100 - 150 families, the event sponsored by 13 organizations was *successful in enrolling 209 families (489 children)*. Partners in the event included the Milpitas Unified School District, Santa Clara Family Health Plan, several local hospitals, CBOs, and community clinics. State Senator Liz Figueroa was an active supporter and attended the event. An additional 44 individuals volunteered childcare and support to families. School buses made multiple stops throughout the day to provide families with transportation.

- Efforts have been made to replicate this model. On February 27, 1999, a similar event was conducted in Gilroy, California. Estimates show that between 200 to 300 children were enrolled during the event.

David and Lucille Packard Foundation Grant
Following the development of the School Outreach Plan, the David and Lucille Packard Foundation invited DHS to submit a proposal to carry out the Plan. DHS was awarded funding at approximately $200,000 for one year, beginning January 1, 1999, with possible renewal for a second year. The Packard Foundation Grant gives DHS the ability to dedicate staff time to state-level school outreach efforts for HFP/MCC.

Federal Outreach Efforts
There were several outreach efforts initiated by the federal government that are designed to increase enrollments in the State's children's health insurance programs (SCHIP) and Medicaid. These include collaboration with federal agencies that have direct daily contact with targeted populations, as well as nationally sponsored outreach messages.

Facilitated by the Health Care Financing Administration (HCFA), DHS has provided overviews of HFP/MCC and distributed collateral marketing materials to the Volunteer Income Tax Assistance (VITA) coordinators at IRS training sessions in northern California. DHS had collateral marketing materials sent to the Los Angeles District office of IRS to be distributed at Earned Income Credit (EIC) Tax Fairs throughout southern California.

DHS and MRMIB made a HFP/MCC presentation late in 1998 in Richmond, California to HCFA and SSA staff and made arrangements with HUD and the SSA to have HFP and MCC collateral marketing materials distributed at all HUD and SSA offices in California.

Outreach efforts by the National Governor's Association (NGA)
To support and promote the States' efforts to publicize the SCHIP and expansions in Medicaid for children, the NGA launched a national outreach campaign and toll-free hotline. This campaign is sponsored by the NGA, in collaboration with states, the White House, HCFA and other partners. The national campaign, entitled INSURE KIDS NOW, launched February 23, 1999, during a press conference at the White House.

English and Spanish radio ads feature the line, "Insure your kids now, call 1-877- KIDS NOW, 1-877-543-7669." This national toll-free number automatically connects Californians to the HFP and MCC toll-free outreach service (1-888-747-1222).

Education

The primary goal of the HFP/MCC education campaign is to build public awareness about the availability of low-cost and no-cost health insurance coverage for children. This goal was accomplished by promoting a "call to action" theme through advertising, public relations, community events, and collateral marketing materials.

Toll Free Telephone Lines
The course for implementing the "call to action" theme to the eligible target population is through toll-free telephone services. HFP/MCC employs two separate and distinct lines: a toll-free HFP/MCC outreach line that acts in concert with program marketing and a toll-free HFP information line that provides account, application and billing information to participants.

One of the most direct indicators of the success of the education campaign is the volume of calls to the toll-free lines. The toll-free lines are routinely monitored to evaluate any required modifications to the education component of the campaign and to guide or modify future campaign activities.

All campaign education materials and activities are designed to generate public awareness of HFP/MCC and consistently promote the toll-free numbers.

Toll-Free Outreach Line, 1-888-747-1222
This telephone service was originally established as part of the MCC campaign in February 1998 and served as a pre-enrollment activity for the HFP.

The statewide toll-free outreach line provides one-on-one guidance and information to the caller about HFP/MCC application process and initiates referrals to EEs. The line supports HFP/MCC outreach such as television, radio, outdoor and print advertising, collateral marketing materials, public relations activities and the HFP/MCC joint application by providing a number for the public to call for an application, information, and referral services. Since January 1999 all new callers have been informed about the availability of EEs and referral information. An average of 12,000 callers per month have granted permission for an EE to follow-up with their family to assist in completing the application.

The Toll-Free Outreach Line is staffed by a team of operators proficient in eleven designated languages which campaign materials are published (English, Spanish, Vietnamese, Cantonese, Cambodian, Hmong, Russian, Armenian, Farsi, Lao and Korean).

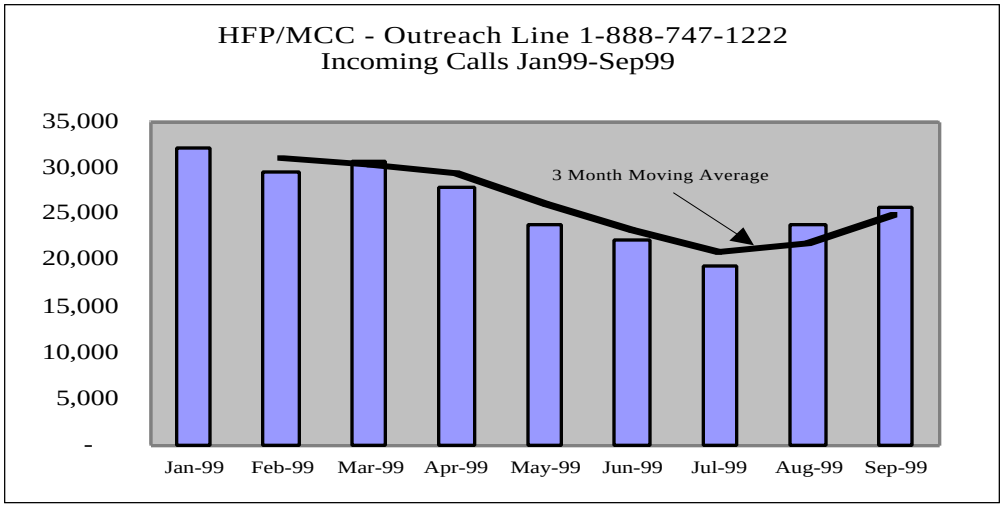
The Toll-Free Outreach Line is staffed Monday through Friday, 8 a.m. to 8 p.m. Pre-recorded information in eleven languages is available 24 hours a day, 7 days a week, including holidays. After hours, a caller may leave a voice mail message to request an application or other information.

The role of the operators is to respond to requests for applications, to assist with questions about the application packet, respond to inquiries about the $50 assistance fee from EEs, and provide referrals to EEs.

Operators transfer calls regarding HFP/MCC to the enrollment staff at the administrative vendor. Operators also refer callers who have complex Medi-Cal eligibility questions or have previously submitted the mail-in application for the Medi-Cal program to county Medi-Cal eligibility workers.

Operators receive ongoing training on customer service techniques, general HFP/MCC program information, as well as state-approved scripted responses for the most frequently asked questions. Scripted information includes program descriptions, eligibility criteria for the HFP, MCC and pregnant women. In addition, information on the availability of free assistance in completing the application by trained and certified EEs, and responses to questions about public charge issues is provided.

As of September 30, 1999, the joint HFP/MCC *Toll-Free Outreach Line* has responded to over ***450,000*** callers. The primary languages of callers are English (approximately 70 percent) and Spanish (approximately 28 percent).

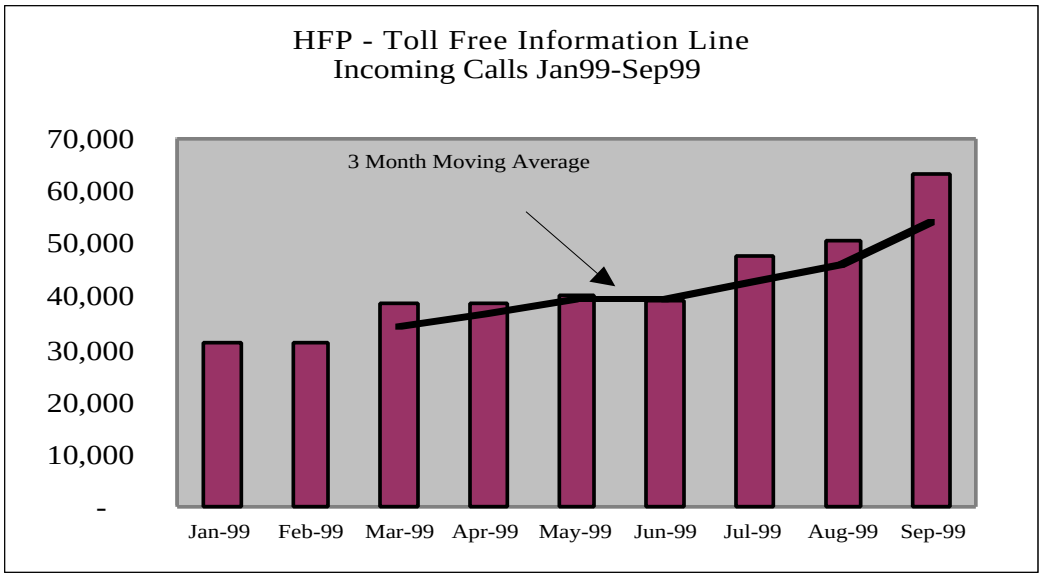


Toll-Free Information Line (1-800-880-5305)
This telephone service was established and is administered by MRMIB's contract with the administrative vendor, EDS. Enrollment specialists offer HFP information, enrollment assistance, account maintenance, billing information and joint application support to families.

The line is staffed by a team of operators proficient in eleven designated languages which campaign materials are published (English, Spanish, Vietnamese, Cantonese, Cambodian, Hmong, Russian, Armenian, Lao, Farsi and Korean).

The phone line is staffed Monday through Friday, 8 a.m. to 8 p.m. Pre-recorded information in eleven languages is available 24 hours a day, 7 days a week, including holidays. After hours, a caller may leave a voice mail message to request an application or other information.

As of September 30, 1999, the line has responded to over ***600,000*** callers. The primary languages of callers are English (approximately 70 percent) and Spanish (approximately 28 percent).



Advertising and Media

Television
Television was the primary medium to convey the HFP/MCC messages and creates an overall recognition of the program. Television was chosen because it is the most heavily used medium in low-income households, regardless of ethnicity. The television spots were developed in both English and Spanish and broadcast statewide to promote public awareness.

Radio
Radio was selected to complement general market television advertising, launch the campaign and reinforce messages, especially among the younger population. For Hispanic advertising, radio was recommended as a primary vehicle in key markets to provide a strong call-to-action (i.e., call the toll-free information line). These spots were produced in English and Spanish.

Outdoor Advertising
Outdoor ad postings complement radio, television and print to provide further visual stimulation and call-to-action. The campaign developed and posted outdoor advertising statewide in nine languages: English, Spanish, Vietnamese, Hmong, Chinese, Loa, Russian, and Cambodian. These ads were posted throughout the State in four different sizes to effectively reach target audiences. To further reach the Latino population, Spanish language interior bus cards were placed in bus routes with high Latino ridership.

Ethnic Print
Ethnic advertising strategy was based on reaching the targeted populations with the available advertising budget. Print ads and outdoor advertising were selected as the most cost effective and efficient advertising strategy to reach targeted ethnic groups based on population and geographic cluster areas of the State. As a result of the contractor's negotiations, the campaign has received bonus advertising and added value in the form of reduced outdoor and print rates and extended editorial coverage in the ethnic newspapers.

Ethnic print ads were developed to target selected under served communities statewide. The HFP/MCC ethnic print ads were developed in five languages – English, Spanish, Vietnamese, Chinese and Cambodian.

Public Relations
The primary purpose of the public relations component of the campaign is to educate the public about HFP/MCC. This is achieved through geographically and culturally diverse local community events that generate local media attention for the campaign, special market projects to reach out to the multicultural communities, with an emphasis on the Latino community, and cross-cultural and ethnic-specific initiatives.

The campaign's media relations program generates accurate news coverage on an ongoing basis in a variety of mainstream and multicultural outlets. There is an emphasis on major daily newspapers and the Hispanic media. Key messages are communicated primarily through trained State spokespersons and credible third party endorsers who regularly participate in radio, television, and newspaper interviews.

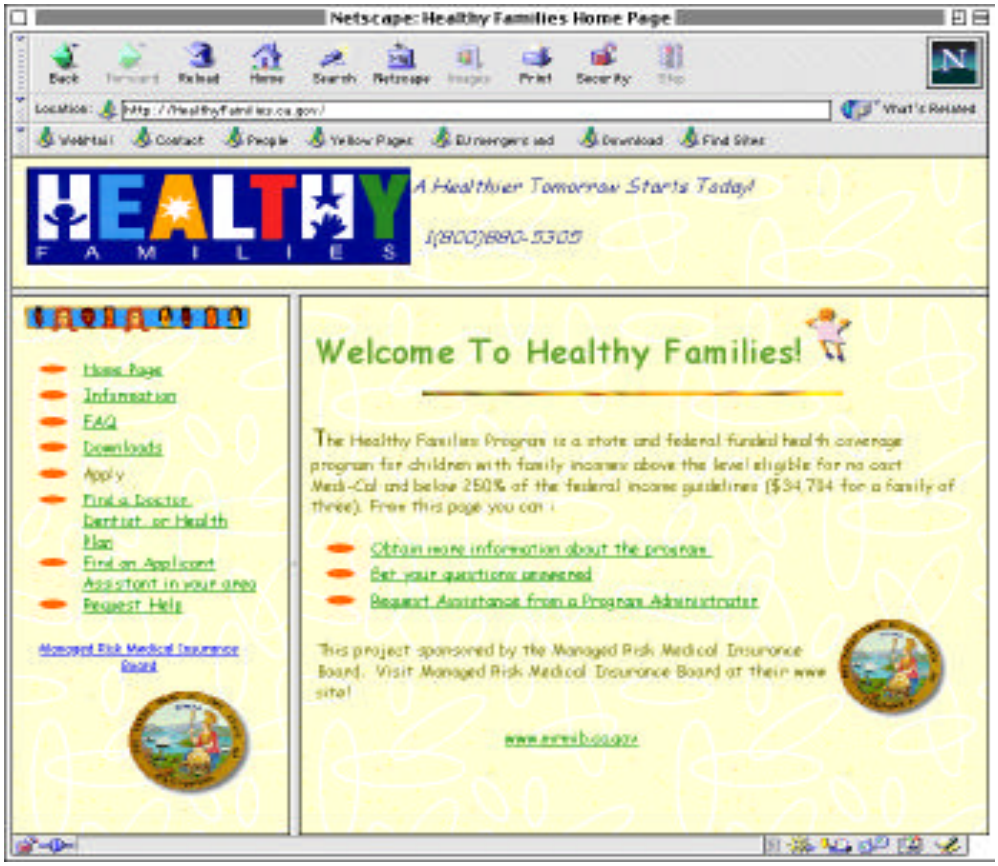
The HFP/MCC education and outreach campaign has built an impressive corporate sponsor base since its launch. The 20 current or committed sponsorships provide added value and visibility to the campaign as well as reinforcement of other outreach efforts by allowing for distribution of campaign collateral marketing materials, and the display of HFP/MCC messages to both the target population and community leaders.

Collateral Marketing Materials
A variety of collateral marketing materials in eleven languages support the CBO's public relations/media activities, sponsorship, and spokesperson efforts to further reach the targeted populations.

Healthy Families Internet Website
The Healthy Families Program has a successful website that provides program information, application assistance, guidance, and help in locating a health plan and physician.

It stresses the availability of program personnel to help in the application process. The toll-free information number is provided.

This site also links to the Managed Risk Medical Insurance Board site which provides statistics on program enrollment, contracts and general information on other health programs administered by MRMIB.



Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (_=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1						
Approach	*Medicaid CHIP Expansion*		*State-Designed CHIP Program*		*Other CHIP Program* AIM*	
	Y = Yes	*Rating (1-5)*	*Y = Yes*	*Rating (1-5)*	*Y = Yes*	*Rating (1-5)*
Billboards	*Y*	*4*	*Y*	*4*	*Y*	*3*
Brochures/flyers	*Y*	*4*	*Y*	*4*	*Y*	*4*
Direct mail by State/enrollment broker/administrative contractor	*Y*	*4*	*Y*	*4*	*Y*	*3*
Education sessions					*Y*	*4*
Home visits by State/enrollment broker/administrative contractor						
Hotline	*Y*	*4*	*Y*	*4*	*Y*	*4*
Incentives for education/outreach staff	*Y*	*5*	*Y*	*5*		
Incentives for enrollees						
Incentives for insurance agents	*Y*	*3*	*Y*	*3*	*Y*	*5*
Non-traditional hours for application intake	*Y*	*3*	*Y*	*3*		
Prime-time TV advertisements	*Y*	*4*	*Y*	*4*	*Y*	*4*
Public access cable TV	*Y*	*3*	*Y*	*3*	*Y*	*3*
Public transportation ads	*Y*	*4*	*Y*	*4*	*Y*	*4*
Radio/newspaper/TV advertisement and PSAs	*Y*	*4*	*Y*	*4*	*Y*	*4*

Signs/posters	*Y*	*3*	*Y*	*3*	*Y*	*3*
State/broker initiated phone calls					*Y*	*3*
WEBSITE	*Y*	*3*	*Y*	*3*	*Y*	*3*
PAYROLL INSERT					*Y*	*4*

**Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

3.4.2 Where does your CHIP program conduct client education and outreach?

This section will reiterate the main channels of outreach and education. Detailed descriptions of the many tools, media, and partners are discussed in question(3.4.1).

Community Based Organizations (CBOs)

The primary outreach support component of the HFP/MCC program is the network of community-based organizations (CBOs) that outreach to families of potential applicants. To facilitate the CBOs' individual needs and strategies, CBOs are able to apply for contract funds or receive application assistance fees. The State continues to support CBOs with toll-free telephone lines for application assistance, publishing information newsletters about program or policy, providing appropriate training/presentations, and distributing applications and collateral materials. The term CBO is used broadly in this report to describe organizations in the community that interact with families with children. Their roles include:

- Health Fairs
- Community Meetings
- School Based Functions
- Public Forums
- Clinics

Schools

The HFP/MCC has used schools as a main avenue for outreach. Outreach efforts related to schools include, grant funding, a formal School Outreach Plan, a School Health Advisory Group for Health Care Access, direct mailings, technical assistance, newsletters, and an internet website. The program has identified schools throughout the State with a high eligible population of children on the Free or Reduced Lunch Program. The program also works with Parent Teacher Association (PTA) groups and other school organizations to increase program awareness and assist them with enrollment activities at school fairs or child care related community functions.

Corporate Sponsors

Sponsors representing a wide variety of industries have volunteered to provide various types of support including; promotion support, information dissemination, endorsement, underwriting and/or in-kind contributions.

Below are samples of sponsors who have participated during the reporting period.

Sponsor	Business	Level of Support
Edison International/Southern California Edison	Public Utility	Provided a HFP/MCC billing insert to 4.5 million customers, representing 11 million people. Special service messages at baseball games.
Raley's/BelAir Supermarkets	Supermarket Chain(Major)	Panel space on milk and juice cartons. Paper shopping bags, and backs of cash register receipts. Panel cards available at checkout and pharmacy.
Rite Aid Drugstores	One of America's largest drug store chains.	Display English-Spanish material in 650 stores, informational stuffers in pharmacy purchases, hosted enrollment event in Los Angeles. Provided speaker for event.
LA County Metro	County Transportation	Donated space on 2200 buses with tearoffs in Spanish-English. Estimated 350 million impressions per year.
Bay Area Rapid Transit	Metro Transportation(SF Bay Area)	Donated space on 56 Metro Monitors in San Francisco and Oakland with HFP/MCC campaign messages.
Founders National Bank	African American owned Bank	Distributed bilingual informational materials in Los Angeles branches.
Circle K Stores	Retail Convenience	Distributed bilingual collateral materials in 407 stores.
Food 4 Less	Retail Supermarket Chain	Distributed bilingual collateral materials in 80 Los Angeles stores.
VitaSoy USA	Soy based beverages	Donated ad space in newspaper and television ads.
Ranch 99 Market	Chinese independent Supermarket chain	Distributed information in 10 stores statewide.
Los Angeles Galaxy	Major League Soccer	Public address time and scoreboard space to English and Spanish messages.
Public Agencies	State, County, Local	Miscellaneous services.

H & R Block Tax Preparation Centers
A program was initiated to train tax preparers at over 400 H&R Block offices throughout California. It was recognized that families who received Earned Income Tax Credits (EITC) might be eligible for the Healthy Families Program.

MRMIB staff developed and implemented an outreach and training project with H&R Block to enroll HFP children during the 1999 tax season.

Under MRMIB and DHS review and approval, H&R Block has promoted the HFP by distributing collateral materials at branch offices, broadcasting HFP advertising on local radio stations, and conducting community outreach efforts in a variety of venues such as department stores, schools and other events.

Insurance Brokers Training and Certification:
Insurance agents may receive reimbursement for providing assistance to families who enroll in HFP and MCC. The Health Underwriters Association requested MRMIB staff to train insurance brokers on completing the HFP/MCC application.

MRMIB developed and implemented a “train the trainer” approach similar to the H&R Block experience described above. The Underwriters Association has more than 8,000 members and they plan to include HFP/MCC training materials into their continuing education curriculum in the future.

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (❄=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* AIM	
	= Yes	Rating (1-5)	= Yes	Rating (1-5)	= Yes	Rating (1-5)
Community sponsored events	**Y**	**5**	**Y**	**5**	Y	4
Beneficiary's home	**Y**	**3**	**Y**	**4**		
Day care centers	**Y**	**2**	**Y**	**2**	Y	3
Faith communities	**Y**	**3**	**Y**	**3**	Y	3
Fast food restaurants						
Grocery stores	**Y**	**2**	**Y**	**2**	Y	3
Homeless shelters	**Y**	**2**	**Y**	**2**		
Job training centers					Y	3
Laundromats	**Y**	**2**	**Y**	**2**		
Libraries	**Y**	**2**	**Y**	**2**	Y	2
Local/community health centers	**Y**	**5**	**Y**	**5**	Y	4
Point of service/provider locations	**Y**	**4**	**Y**	**4**	Y	4
Public meetings/health fairs	**Y**	**3**	**Y**	**3**	Y	3
Public housing	**Y**	**2**	**Y**	**2**		
Refugee resettlement programs						
Schools/adult education sites	**Y**	**4**	**Y**	**4**	Y	3

Senior centers						
Social service agency	**Y**	**5**	**Y**	**5**	Y	3
Workplace	**Y**	**3**	**Y**	**3**	Y	4
Other (specify) TAX PREPARERS	**Y**	**2**	**Y**	**2**	Y	2
Other (specify) INSURANCE AGENCIES	**Y**	**2**	**Y**	**2**	Y	4

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Reduction in uninsured target population.
The estimated baseline number of uncovered low-income children eligible for the Healthy Families Program as of 9/30/99 was **328,000**. The total number of children ever enrolled from implementation to 9/30/99 was **178,725.**

It is estimated that the reduction in the percentage of uninsured children in target income families that have family income above no cost Medi-Cal is approximately 54%.

Progress Toward Goal = 178,725 / 328,000 = ***54%***

This measure illustrates the relative speed of California's progress in meeting the goal. During 1998/99 many positive changes were implemented to attract, enroll, and retain the target population. The program has shown its greatest growth during the later half of the reporting period. We are especially pleased with the level and growth of the Hispanic component of the enrollee base.

Applications Distributed
Over 350,000 applications were distributed to interested parties.

Ethnic Penetration
The Hispanic population comprises 60% of the total enrolled base in the HFP. Over 80% of total enrollment occurred in the Hispanic (60%), African American (3%), and Asian Pacific Islander (15%) ethnic groups.

Geographical Penetration
Over 60% of the total enrollees live in the Los Angeles/San Diego region. The remaining 40% are spread over the 52 smaller counties within the State. In the smaller county penetration, the median county enrollment is approximately 1,000 enrollees.

Enrolled Entities application assistance fees
As of 9/30/99, $3.2 million has been paid to "Enrolled Entities" for application assistance fees. Of the over 4,000 "Enrolled Entities" 46% have submitted the documentation to receive a reimbursement for assisting with enrollment of children into HFP or MMC. The number of entities requesting reimbursement has increased by 72% from the beginning of 1999. The number of participating enrolled entities has grown by 42% since the beginning of 1999.

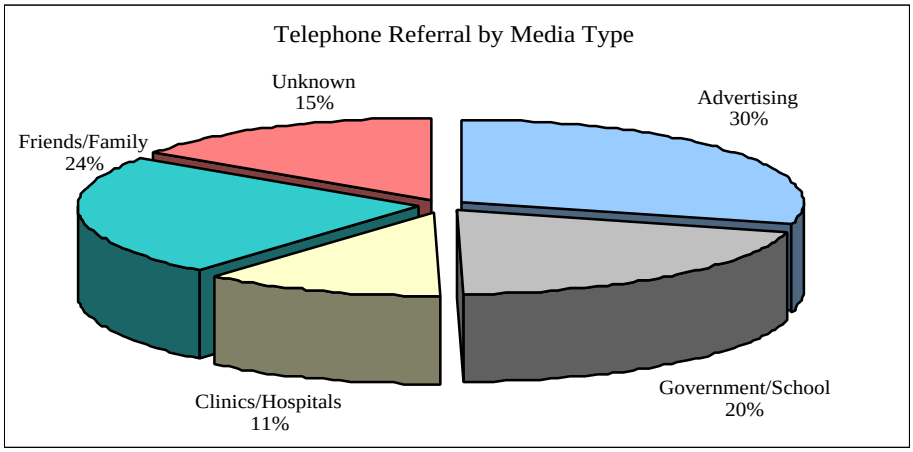
Contract initiated with Community Based Organizations
As of 9/30/99, there were over 4,000 organizations participating in the outreach campaign. A total of $6 million was allocated to outreach contracts in SFY 1999-2000 from a total outreach budget of $21 million. This represents 28.5% and a significant effort in utilizing this approach. A total of $1 million was allocated to outreach contracts in SFY 1998-1999.

Toll free telephone services

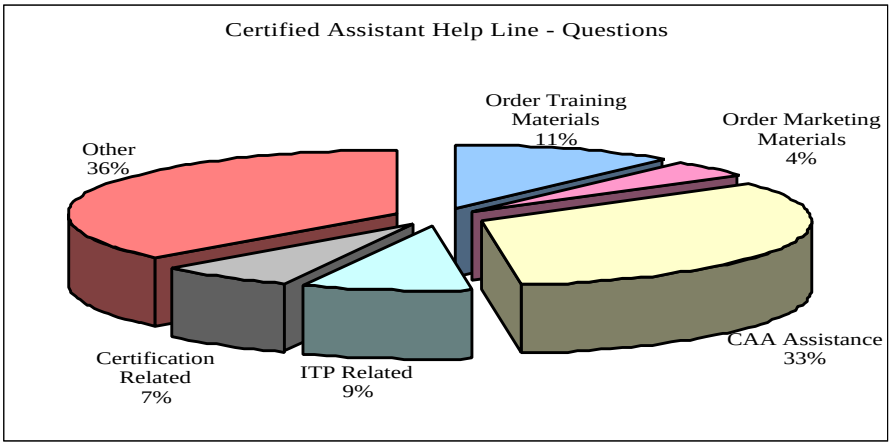
An indicator of advertising success is call volume during weeks when the campaign ads were aired. During media campaign weeks, calls increased by 80% compared to non-media weeks. From an average of ***9,000*** per month during the later half of 1998, HFP enrollments reached over ***13,000*** per month in February 1999 and continued to achieve between ***14,000 and 18,000*** per month through 9/30/99.

The campaign's momentum has increased considerably since implementation, due in part to the success of its advertising and media coverage. They generated not only broad-based public awareness of the new health care programs, but they also prompted a very high response to the campaign's toll-free phone lines. A key measure of its success is the high call volume to the toll-free lines. As of September 1999, operators have responded to ***over 1,000,000*** calls.

Additionally, when operators asked callers during the first six months of the campaign how they heard about the new program, 30 percent of them identified advertising as the primary source. Caller referrals are tracked through the *toll free outreach* line based on advertising media origin. The following chart represents data for the 1999/2000 FFY.



The State has established a *"CAA Help Line"* to provide education and outreach materials, along with assisting the CAAs on commonly asked questions. This line answers over ***1,000*** calls per week and has received about ***70,000*** call since program implementation. The following table represents a breakdown of the most common requests from CAAs.



Surveys
A survey of EEs was also conducted to evaluate the effectiveness of the State's outreach strategies.

Research Consultants
Research Consultants are comprised of subcontractors and consultants who participate in the development and production of all advertising, media buying and ad placement. The contractor team includes representatives of the Latino, African-American, Asian, and Native American communities.

Focus Groups
Another integral phase of creative material development is focus group testing to assess reactions to creative materials in order to refine messages and strategies for key target populations. A total of eight formal focus groups were conducted prior to production of the campaign advertising.

Additional informal focus group testing was conducted with community leaders and influencers representing Chinese, Vietnamese, Lao, Cambodian, Hmong, Russian, Farsi, Armenian, Latino and African-American target audiences.

1999/2000 Outreach and Education Evaluation
The Outreach and Education Evaluation for the State Fiscal year 1999/2000 will be issued in 2000 and further describes current program performance.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Ethnic Advertising

To ensure that advertising reached targeted ethnic groups, the campaign utilized contractors, multicultural and multi-ethnic consultants, and focus groups comprised of representative target populations. Ads were placed primarily on English and Spanish language television and radio to specifically reach lower-income, ethnically targeted populations.

The contractor team is comprised of subcontractors and consultants who participate in the development and production of all advertising, media buying and ad placement. The contractor team includes representatives of the Latino, African-American, Asian, and Native American communities.

Ethnic print ads were developed to target selected under-served communities statewide. The HFP/MCC ethnic print ads were developed in five languages – English, Spanish, Vietnamese, Chinese and Cambodian. Provided below is a summary of HFP/MCC ethnic advertising buy strategies during the first six months of FY 1998-99:

- ***Latinos****:* Television, radio, outdoor and print advertising have been used statewide to reach Latinos. Twenty percent of statewide media dollars have been dedicated to the Spanish-language media market. In Los Angeles, 28 percent of the population is Spanish-language dominant, and more than 29 percent of HFP/MCC campaign spending in Los Angeles has been in Spanish-language media. On a per capita basis, Latinos were over targeted with HFP/MCC advertising messages by at least six percent.

  In addition, MRMIB bilingual English and Spanish staff participated in television, radio news interviews talk shows, newspaper articles, press conferences, and community forums focusing on the availability of HFP/MCC to heighten program awareness and increase enrollments. These public relations efforts were highly successful in generating calls to the toll-free line requesting copies of the application and more information about eligibility for HFP/MCC.

- ***African-Americans****:* A mix of television, radio and print has been utilized to reach African-Americans statewide. Three percent of statewide media dollars have been directed to African-American newspapers; the general market placements have been predominantly in lower-income, ethnically skewed mediums and communities. Additionally, 26 African-American newspapers have been featuring HFP/MCC advertising every month since September 1998.

- ***Asians****:* Five Asian ethnicities have been targeted with in-language HFP/MCC print and outdoor advertising messages: Chinese, Cambodian, Vietnamese, Hmong and Lao. More than four percent of the media budget has been dedicated to this effort on 60 billboards and in 15 newspapers statewide

Toll-Free Information Service

The line is staffed by a team of operators, proficient in eleven designated languages, in which campaign materials are published (English, Spanish, Vietnamese, Cantonese, Cambodian, Hmong, Russian, Armenian, Farsi, Lao and Korean).

Language	Program to Date	% of Total
English	456,371	68.50
Spanish	188,931	28.36
Cantonese	14,374	2.16
Korean	2,088	.31
Vietnamese	2,015	.30
Armenian	1,408	.21
Russian	391	.06
Cambodian	351	.05
Hmong	127	.02
Farsi	105	.02
Lao	95	.01

The MRMIB/HFP toll-free line has received over ***200,000*** calls from non-English speaking persons who were interested in receiving information and materials.

Ethnic Community Public Relations

Public relations community outreach programs are designed to develop relationships with community and employment organizations in under-served ethnic communities to increase and encourage ethnic enrollment. All field staff are fluent in more than one language and can assist in enrollment efforts in ethnic communities. The following languages and dialects can be serviced:

English	Hainamese	Spanish
Tagalog	Vietnamese	Cebuano
Cantonese	Cambodian	Mandarin

A total of eight formal focus groups were conducted prior to production of the campaign advertising. Additional informal focus group testing was conducted with community leaders and influencers representing Chinese, Vietnamese, Lao, Cambodian, Hmong, Russian, Farsi, Armenian, Latino and African-American target audiences.

As a result of the FY 1999-2000 State Budget Act, the HPF/MCC campaign budget was increased by $1.77 million to focus on expanding enrollment of eligible children living in immigrant communities that are under served and linguistically diverse. The goals of these activities include:

- Increase enrollment of eligible children
- Raise overall public awareness about the HFP/MCC within the targeted population
- To educate the families of potentially eligible children about the benefits of preventative care and availability of State-sponsored health coverage for children
- To increase calls to the HFP/MCC outreach toll-free phone line 1-888-747-1222

Latino, African-American, Asian, Armenian, Russian, Farsi, and Cambodian communities are targeted through a variety of radio, television, print and public relation outreach.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

School Outreach

As part of the School Outreach Plan, a direct mailing was sent to California's 7,000 principals and 1,058 superintendents. This resulted in significant action at school sites to promote and increase awareness of HFP/MCC among California's families. Over **500** orders were requested from schools/school districts throughout California. This is over **500,000** parent information sheets. During the first 6 months of the 1999-2000 State fiscal year, it is estimated that this outreach method produced a response rate of 30%.

Community Based Organizations(CBOs)

The outreach created through out partnerships with CBO's has allowed the program to inform and educate the hard to reach target populations. The "localized" nature of this approach has allowed the program flexibility in reaching the diverse nature of California's population. Cultural and linguistic barriers have been removed through the participation and training of Certified Application Assistants who are members of the community, speak the language of the subscriber, and share common cultures. The CBOs have been awarded contracts of $1 million during the period, with an additional $6 million allocated for the 1999-2000 SFY.

Media, Television and Radio

An indicator of advertising success is call volume during weeks when the campaign ads were aired. During media campaign weeks, calls increased by 80% compared to non-media weeks. From an average of 9,000 per month during the later half of 1998, HFP enrollments reached over 13,000 per month in February 1999 and continued to achieve between 14,000 and 18,000 per month through 9/30/99.

The campaign's momentum has increased considerably since implementation, due in part to the success of its advertising and media coverage. They generated not only broad-based public awareness of the new health care programs, but they also prompted a very high response to the campaign's toll-free phone lines.

"Enrolled Entities" application assistance fees

As of 9/30/99, $3.2 million has been paid to enrolled entities for application assistance fees. Of the over 4,000 "Enrolled Entities" 46% have submitted the documentation to receive a reimbursement for assisting with enrollment of children into HFP or MMC. The number of entities requesting reimbursement has increased by 72% from the beginning of 1999. The number of participating enrolled entities has grown by 42% since the beginning of 1999. Of the applications received during the reporting period, 60% were completed with the help of a CAA.

Toll Free Telephone Lines

A key measure of its success is the high call volume to the toll-free lines. As of 9/30/99, operators have responded to ***over 450,000*** calls to the HFP/MCC Outreach Line and ***over 650,000*** calls to the information line. This represents ***over 1,000,000*** calls.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid*	CCS	Other (specify) CHDP	County Mental Health
Administration	Y	Y	Y	Y
Outreach	Y	Y		
Eligibility determination	Y	Y	Y	Y
Service delivery	Y	Y	Y	Y
Procurement	Y			
Contracting	Y			
Data collection	Y	Y		
Quality assurance				
Data Analysis	Y	Y		
Other (specify)				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

Coordination

Eligibility, Service Delivery, Administration

Medi-Cal
California recognizes that coordination between HPF and Medi-Cal is an important factor in ensuring that low-income families have access to continuous health care coverage.

Both programs rely on income, family size and income deductions to determine a child's eligibility. An individual or entity assisting a low income family to screen for the program for which they are eligible needs to determine income, family size, and age of children in order to refer the family to the appropriate program.

A *joint application* form for both the Healthy Families Program and Medi-Cal has been successfully implemented.

A **"***single point of entry*" screening process has been developed for HFP/MCC children:

- The enrollment contractor forwards applications of families found to have incomes too low to qualify for the Healthy Families Program directly to the appropriate county for Medi-Cal determination.

- When children served by Medi-Cal experience increased family incomes which would cause them to no longer be eligible for no cost Medi-Cal coverage, they are granted an additional one month of eligibility to give them adequate time to apply for and enroll in the Healthy Families Program. Medi-Cal eligibility workers are equipped to refer such families to the Healthy Families Program and may distribute the joint Medi-Cal for Children/HFP mail-in application to them.

Implementing a resource disregard for children in the Medi-Cal federal poverty level programs and utilization of income deductions in the Healthy Families Program further facilitate coordination between Medi-Cal and the Healthy Families Program. California also closely coordinates with programs offering specialized services beyond the HFP's benefits scope. To meet the special needs of children, the Healthy Families program also ensures the provision of necessary specialized services beyond those offered through the comprehensive insurance package in a coordinated manner.

Child Health Disability Program

Children come to Healthy Families through a "*gateway program"* called CHDP. CHDP organizations provide early medical screens and immunizations (following EPSDT guidelines) for children under 200% of FPL and perform a critical eligibility screening and referral function to HFP. When children receive services from a CHDP provider, they are either referred to Medi-Cal or to the Healthy Families Program. Should follow-up treatment be required for a condition identified in the CHDP screen, Medi-Cal or the Healthy Families Program (depending on which program the child qualifies) cover the cost of care provided to children for 90 days prior to enrollment. Low income children who are ineligible for Medi-Cal or the HFP insurance program

are referred to counties for treatment. The HFP program is designed to closely coordinate with the CHDP program.

California Children Services
The CCS program has been integrated into the HFP benefit design. CCS provides case management and treatment for chronic, serious, and complex physically handicapping conditions. Children receiving such services continue to have their primary health needs served through the Healthy Families Program's health, dental and vision plans. Data on referrals is limited. HFP received ***1,634*** referrals during SFY 1999.

County Mental Health Departments
Children with serious emotional disturbances (estimated at between 3-5% of the general population) are referred by the HFP participating health plans to the county mental health program for treatment. The referral is made, pursuant to a Memorandum of Understanding (MOU) between the two organizations for any needed additional mental health services beyond what is provided in the HFP basic benefit plan. Data on referrals is limited. HFP received ***124*** referrals during SFY 1999.

The required MOU formalizes this important arrangement. The county mental health program coordinates the delivery of mental health and other health services with the health plan for those children who meet the criteria of serious emotional disturbance. County mental health programs provide mental health treatment services directly or through contracts with private organizations and individual providers.

Rural Health
The Department of Health Services (DHS) is authorized to operate up to five pilot programs in rural areas should the coverage provided through the Healthy Families Programs be insufficient in particular rural areas or for particular populations, such as migrant workers or American Indians.

Local Agencies
Healthy Families outreach efforts focus on both targeted low income children who are eligible for the Healthy Families Program and Medi-Cal eligible children who are not yet enrolled in Medi-Cal. The outreach efforts are coordinated as often as possible with other public health programs such as maternal and child health programs, WIC, CHDP and others. Outreach is not only performed by community-based organizations, but by CHDP providers, county health agencies, and other entities serving targeted population groups.

Quality Assurance
The Department of Health Services Medi-Cal Managed Care Program contracts with most of the health plans that participate in the HFP. Because of this overlap, the MRMIB and DHS work together on selecting and developing quality measures.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe Crowd –out policies implemented by your SCHIP Program

Eligibility Determination: In order to prevent crowd-out, applicants must answer questions about the children's previous health coverage. Children who received employer based health coverage 90 days prior to application are not eligible for the HFP.

Benefit Package Design: Participants are required to pay premiums and copayments except for preventative care. Premiums range from $4-$27 maximum per family depending on family size.

3.6.2 How do you monitor crowd-out?

Data collected from the implementation of the HFP indicates that 3.8 percent of successful applicants had coverage through an employer within the prior 90 day period. Of the 3.8 percent of applicants that reported job-based insurance for their children within the previous 90 days, the following reasons were provided for why the children did not have coverage at the time of application or would no longer be covered on the effective date of enrollment:

- 2.24 percent stated their child(ren) would be uninsured due to loss of employment
- 0.15 percent had an address change to where no coverage was available through the employer's plan.
- 0.4 percent had an employer who discontinued benefits to all employees.
- 0.22 percent cited the end of COBRA coverage.
- 0.77 percent listed other.

These numbers indicate that during the reporting period, it does not appear that crowd-out has affected the HFP to any significant degree. Assessing "crowd out" as a result of the Healthy Families Program is further complicated by the relatively recent implementation of the program.

Section 4. Program Assessment

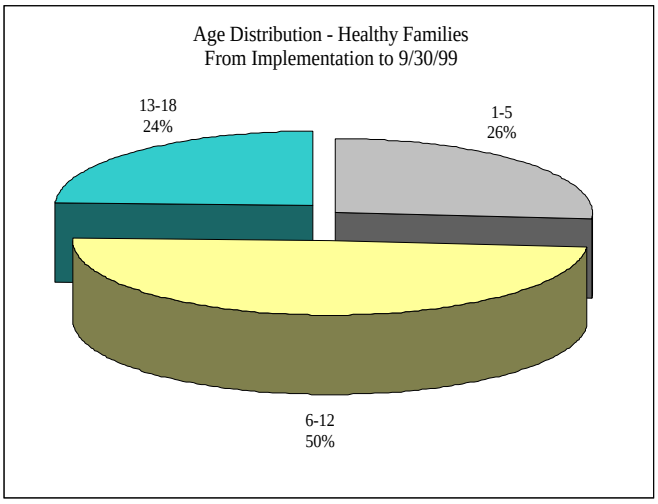
This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

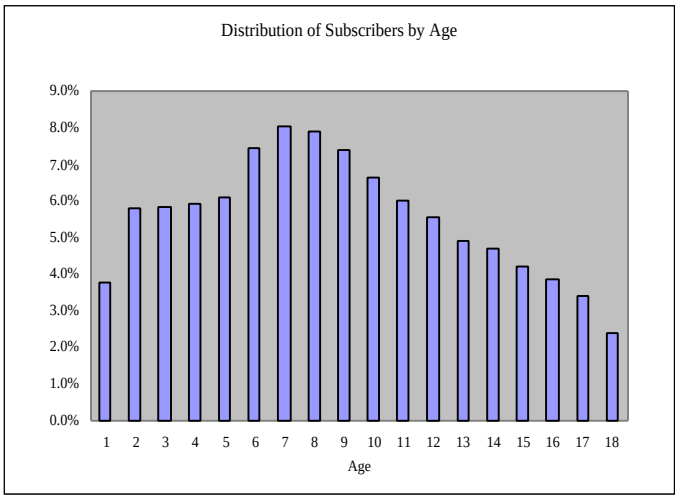
4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program?Section2108(b)(1)(B)(i)) Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

The majority of children enrolled in the Healthy Families Program, 50% are between 5 and 12 years of age. The high age group (ages 13-18) and low age group (ages 1-5) each comprise approximately 25% of subscribers.





Male and female subscribers are equally distributed in the program. Children younger than one were not eligible until November 1999.

Children from families with incomes above 150% of FPL represent the largest income group in the program. Of these families, most of the children are in either the 1-5 or 6-12 age group.

A higher percent of subscribers in the 13-18 age group are in families with incomes below 150% of FPL. This might be due to the fact that HFP covers children ages 1-5 between 133-150% FPL and children 6-18 from 100-150% FPL. The average income of families in the program is 159% of FPL.

The following table describes the percentage mix of children within each income level.

Age of Subscriber	Percent Above 150% FPL	Percent Below 150% FPL
1-5	76%	24%
6-12	51%	49%
13-18	44%	56%

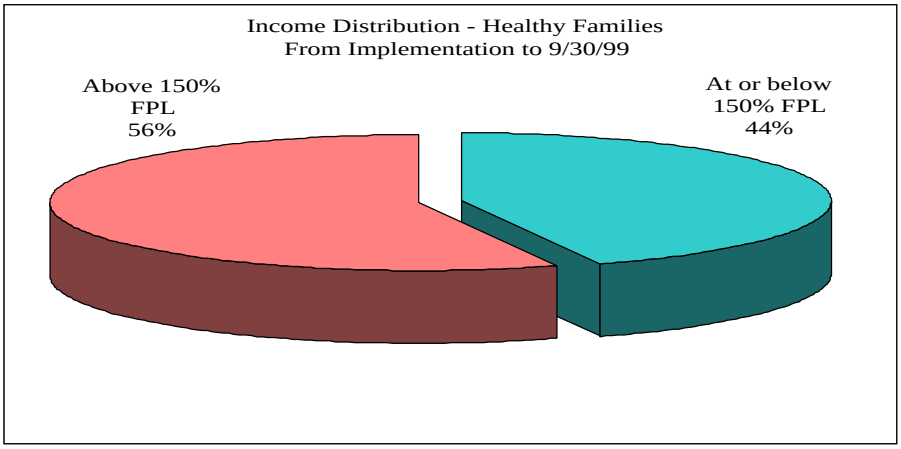
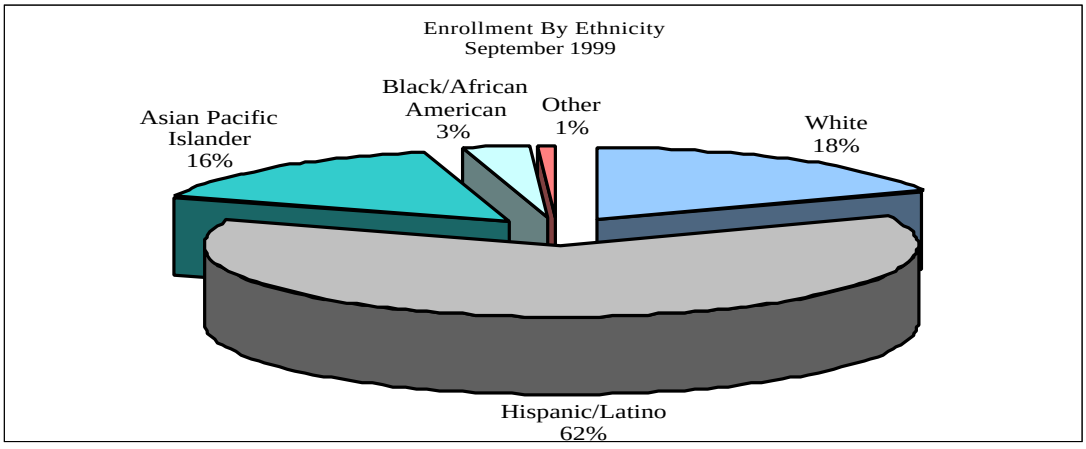


Table 4.1.1 CHIP Program Type SCHIP						
Characteristics	**Number of children ever enrolled**		**Average number of months of enrollment**		**Number of disenrollees**	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	15,984	178,725	1.13	2.58	29	11041
Age						
Under 1	0	0	0	0	0	0
1-5	4,303	48,101	1.11	2.52	8	1,579
6-12	7,852	87,800	1.12	5.59	14	3,179
13-18	3,829	42,824	1.14	2.62	7	1,633
Countable Income Level*						
At or below 150% FPL	7,030	78,602	1.15	2.6	13	5,045
Above 150% FPL	8,954	100,123	1.12		16	5,996
Age and Income						
Under 1						
At or below 150% FPL	0	0	0	0	0	0
Above 150% FPL	0	0	0	0	0	0
1-5						
At or below 150% FPL	1,028	11,494	1.15	2.59	2	694
Above 150% FPL	3,274	36,607	1.12	2.5	5	2,030
6-12						
At or below 150% FPL	3,858	43,141	1.13	2.59	7	2,709
Above 150% FPL	3,994	44,659	1.13	2.58	7	2,783
13-18						
At or below 150% FPL	2,143	23,967	1.13	2.631	4	1,638
Above 150% FPL	1,686	18,857	1.11	2.60	3	1,183
Type of plan						
Fee-for-service						
Managed care Including PPO product	15,984	178,725	1.13	2.58	29	11,041

*SOURCE:HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

Table 4.1.1a provides additional demographic information.

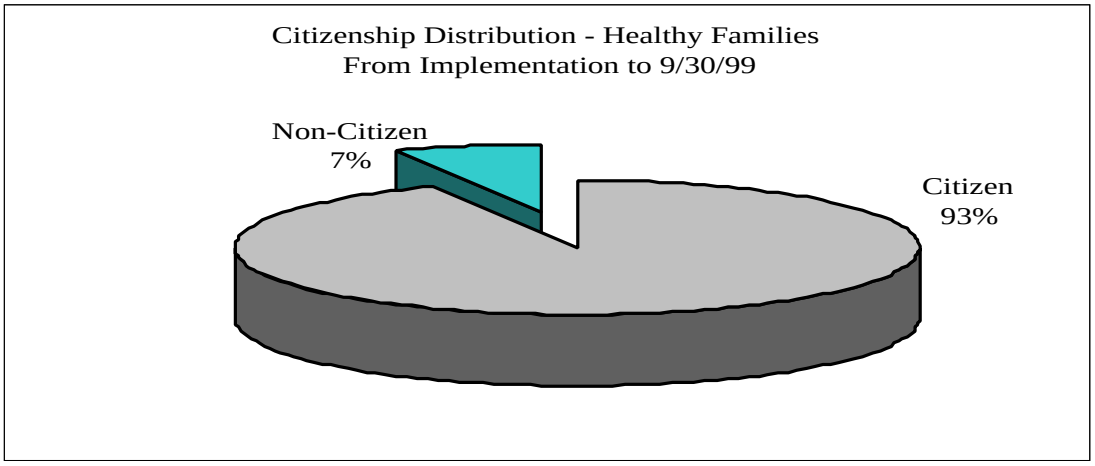
Table 4.1.1 a CHIP Program Type SCHIP						
Characteristics	**Number of children Ever enrolled**		**Average number of months of enrollment**		**Number of Disenrollees**	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Immigrant Status						
Citizen	14729	151598	NA	NA	NA	10,196
Non-Citizen	1266	11195	NA	NA	NA	845
Gender						
Male	8268	83602	NA	NA	NA	5,623
Female	7727	79128	NA	NA	NA	5,418
Ethnicity						
White	4104	27161	NA	NA	NA	2,365
Hispanic	5401	91732	NA	NA	NA	5,428
Asian & pacific	380	2542	NA	NA	NA	148
Other	6110	41358	NA	NA	NA	3,099



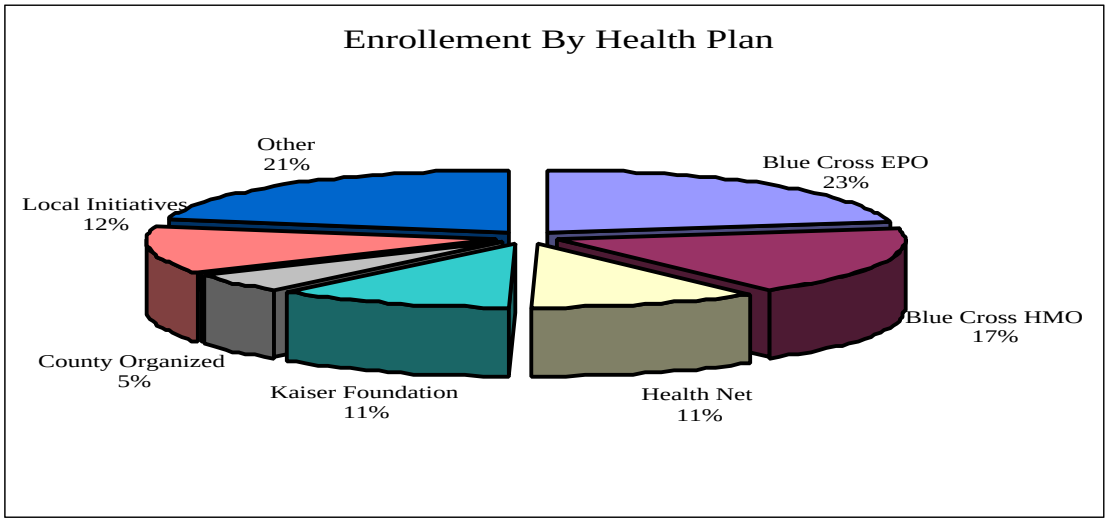
Hispanic enrollment comprises over 60% of the Healthy Families Program. Most subscribers (over 70%) reside in Southern California, with Los Angeles County alone comprising over 30% of the enrollment. The top five (5) counties in that have over 57% of total enrollment include:

Los Angeles County, Orange County, San Diego County, San Bernardino County, Riverside County

Non-citizen participation remains at 7% and has not shown any appreciable trends since implementation.



Approximately 73% of the total subscribers are enrolled with the following organizations. They comprise about 25% of the total number of the participating health plans. The remaining plans serve approximately 27% of the subscribers.



4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Data collected from the implementation of the HFP indicates that 3.8 percent of successful applicants had coverage through an employer within the prior 90 day period. This data is available on the application.

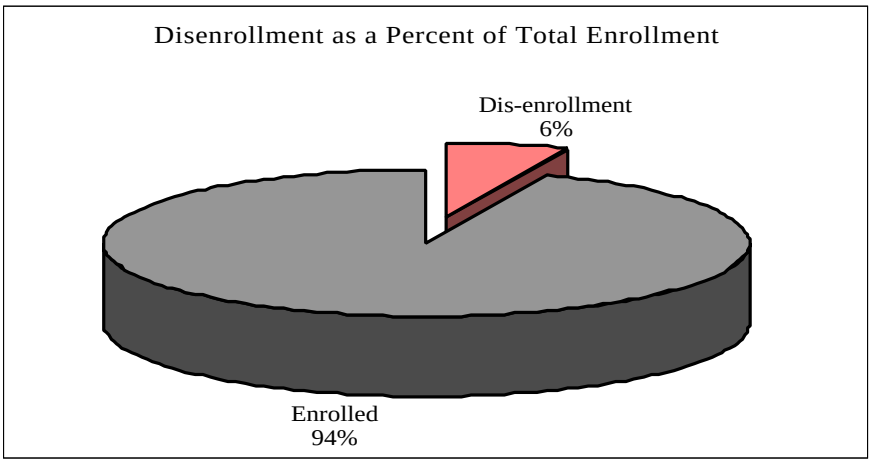
4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Please see section 2.2.1 for a complete description of other programs in California.

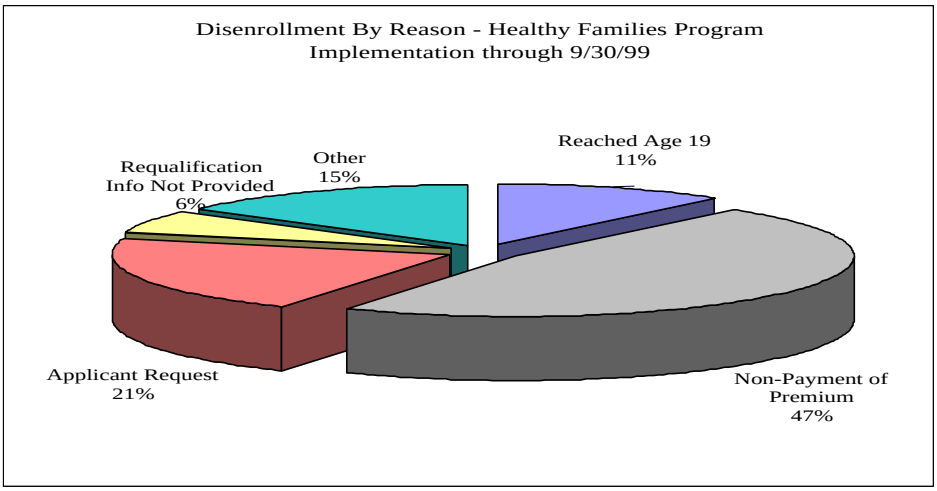
4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

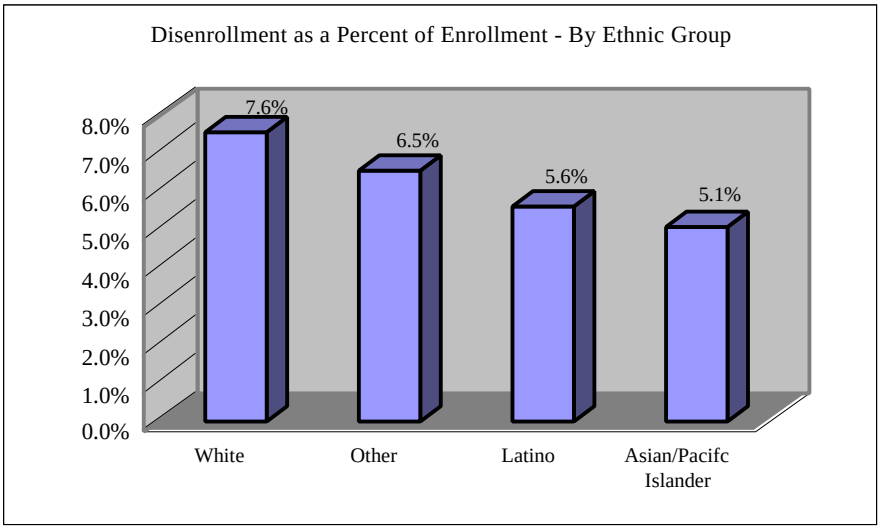
Approximately 11,000 children disenrolled from the Healthy Families Program during the period beginning July 1998 and ending September 1999. Approximately 6 out of 100 (6%) enrollees were dis-enrolled during the reporting period.



The following chart illustrates reasons for disenrollment.



A major observation relative to disenrollment is the variance within ethnic groups. The data also shows that Whites have the highest incidence of disenrollment among the ethnic groups. Latinos and Asian/Pacific Islanders are below 6%.



With the combination of Latino and Asian/Pacific Islander enrollment comprising over 80% of total enrollment (September 1999) and projected to grow during FFY2000, the disenrollment rate may continue to decline below the current aggregate level of 6%.

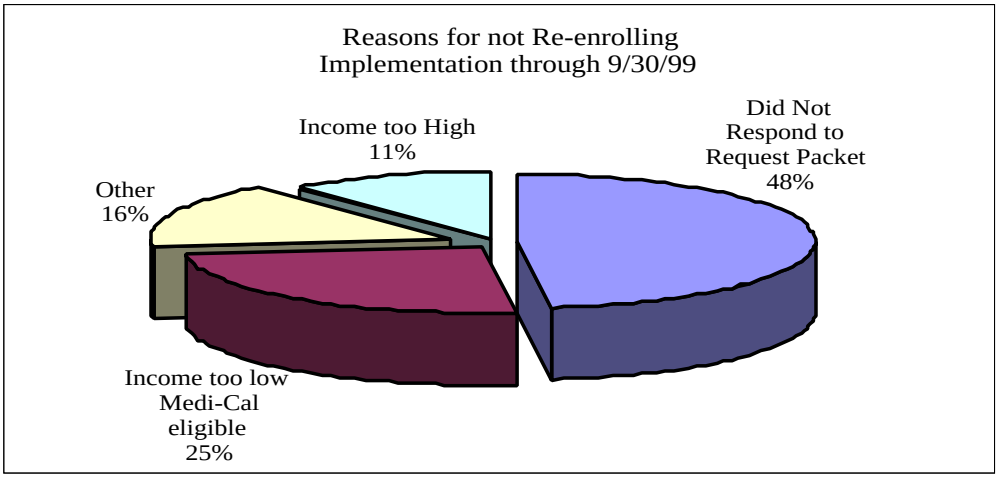
4.2.2 How many children did not re-enroll at renewal? How many of the children who did not reenroll got other coverage when they left CHIP?

During the reporting period**, 2,868** children did not re-enroll. These children were members of **1,435** families. The main reasons for not re-enrolling in the Healthy Families program were:

(48%) Did not respond to requests for re-qualification information. The program makes every available effort to contact the subscriber at time of re-enrollment. Pre-printed packages are sent two months prior to the anniversary date stressing the need to complete the re-enrollment documentation to remain enrolled in the program. The enrollee is contacted on a sliding frequency by telephone and post card as their anniversary date becomes closer.

(36%) Were not eligible at redetermination. 25% of the enrollees were deemed eligible for no cost Medicaid while 11% were disqualified because their family income levels have improved to a point where they no longer meet the income requirements of the program.

(16%) The remainder did not re-enroll due to incomplete documentation (14%), replacement with commercial or employment based coverage (.5%), and other (1.5%).



4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3						
Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program *Based on Family Statistics		Other CHIP Program* AIM	
	Number of disenrollees	Percent of total	*Number of disenrollees	*Percent of total	Number of disenrollees	Percent of total
Total	Not Available		**2,868**	**100**	Not Available	
Access to commercial insurance			**29**	**1**		
Eligible for Medicaid			**717**	**25**		
Income too high			**315**	**11**		
Aged out of program			**29**	**1**		
Moved/died						
Nonpayment of premium						
Incomplete documentation			**401**	**14**		
Did not reply/unable to contact			**1377**	**48**		
Other (specify)						
Other Applicant Request						
Don’t know						

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

The program produces a customized "Annual Eligibility Review Package" for each family. This package is sent to the subscriber 60 days prior to anniversary date. The subscriber is asked to respond within 30 days. If no response is provided within the 30 day time period, a post card is sent out as a secondary reminder. This reminder stresses the fact that coverage will be *cancelled* if they do not respond by the anniversary date. Three telephone calls are also made 30 days prior to the anniversary date. This method provides a comprehensive approach to reaching subscribers with the information and tools necessary to make an informed decision on their participation in the Healthy Families Program.

CAAs are encouraged to keep in contact with individuals they enrolled to continue to promote the program. With this in mind, HFP/MCC has implemented an incentive program that pays $25 for Annual Eligibility Enrollment assistance resulting in a subscriber's re-enrollment.

Annual Eligibility Review data, reported for the period 7/99 through 9/99, showed 80% of the children were found eligible, 10% were found ineligible, and 10% did not respond.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 $ 3,364,760
FFY 1999 $88,885,573

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share).

What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Private health insurance = 98.9% in FFY1998 and 98.8% in FFY1999. The fee for service component is comprised of CCS and County Mental Health programs.

Table 4.3.1 CHIP Program Type: *State CHIP Healthy Families Program*

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	$1,526,621	$82,552,466*	$1,005,433	$54,916,697
		* Includes AIM @$3,557,308		
Premiums for private health insurance (net of cost-sharing offsets)*	$1,510,240	$81,595,193	$994,644	$53,926,263
Fee-for-service expenditures (subtotal) CCS, CMH	$16,381	$957,273	$905,989	$589,169
Inpatient hospital services		8,316		5,496
Inpatient mental health facility services		6,790		4,488
Nursing care services				

Physician and surgical services		82,108		54,265
Outpatient hospital services		27,064		17,887
Outpatient mental health facility services				
Prescribed drugs		22,821		15,083
Dental services		55,963		36,986
Vision services				
Other practitioners' services		165,629		109,464
Clinic services		303,298		200,451
Therapy and rehabilitation services				
Laboratory and radiological services		1,380		912
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services	16,381	259,043	10,789	141,043
Home health		151		100
Home and community-based services		2,985		1,973
Hospice				
Medical transportation		747		494
Case management				
Other services		20,978		527

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share).

What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?
100% spent on purchasing direct services.

Table 4.3.1 CHIP Program Type *MediCal CHIP Expansion*				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		$7,239,046		$4,794,379
Premiums for private health insurance (net of cost-sharing offsets)*		$0		$0
Fee-for-service expenditures (subtotal)		$7,239,046		$4,794,379
Inpatient hospital services		2,253,903		1,489,605
Inpatient mental health facility services		121,704		80,434
Nursing care services				
Physician and surgical services		1,016,795		672,000
Outpatient hospital services		455,456		301,011
Outpatient mental health facility services				
Prescribed drugs		902,579		595,854
Dental services		1,780,158		1,176,508
Vision services				
Other practitioners' services		3,387		13,042

Clinic services		447,984		296,073
Therapy and rehabilitation services		50,368		33,258
Laboratory and radiological services		108,058		71,416
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services		36,254		23,959
Home health		558		369
Home and community-based services				
Hospice				
Medical transportation		6,541		4,323
Case management				
Other services		55,301		36,527

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Payments to Administrative Vendor

These expenses are related to the maintenance of the comprehensive eligibility, enrollment and customer service system.

- Processing and filing (paper and electronic), of the application and all related materials
- Tracking of application status using an integrated database management/imaging system, eligibility determination including Annual Eligibility Review processing and enrollee follow-up
- Toll free information telephone service responding to between 2,500 and 3,000 calls per day
- Coordination with health plans with regard to subscriber enrollment data
- Printing materials
- Responding to program changes such as eligibility requirements

Payments related to Statewide Outreach Campaign

- Funding of Application Assistance Fees. As of September 1999, approximately $3 million has been expended
- Mini-contracts to support Community Based Organization's targeted outreach activities
- Expenses related to the statewide outreach and education campaign
- This includes television, radio, print, public relations and consulting services

(Please see Questions 3.4 and 3.5 for a comprehensive description of all aspects of the HFP/MCC outreach campaign, including media, CBO participation, contracts and strategies.)

What role did the 10 percent cap have in program design?

The 10% cap has created a critical barrier to increasing enrollment in the HFP to its maximum potential. California's significant expenditure over the 10% target illustrates the State's commitment to the goals of the HFP.

As California has maintained, since its submission of the State plan in November 1997, it is not possible for administrative costs to be as low as 10 percent of total expenditures until the base of children has grown. This is especially discriminatory to non-Medicaid expansion states that do not have benefit base.

The initial, and most costly, period of SCHIP implementation is crucial in determining the long-term success of SCHIP. Without adequate federal funding for administration and outreach during the early phase of the programs, states are forced to make the difficult choice between jeopardizing the success of their SCHIP program and allocating funds away from other necessary state funded programs.

Expanding the 10 percent cap during the initial period of SCHIP implementation would provide non-Medicaid expansion states with the resources to implement optimum administrative mechanisms and outreach campaigns.

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share	**	**	$301,518	$10,119,410	**	**
Outreach			133,714	1,153,938		
Administration			167,804	8,965,472		
Other						
Federal share			$195,580	$6,687,918		
Outreach			88,064	762,637		
Administration			110,516	5,925,281		
Other						

** Program data not available at this time.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

_X_ ***State appropriations***
_X_ ***County/local funds***
___ ***Employer contributions***
_X_ ***Foundation grants***
___ ***Private donations (such as United Way, sponsorship)***
___ ***Other (specify) _____***

4.4 How are you assuring CHIP enrollees have access to care?

Assuring access to care begins with the plan networks. Before the program opened to new enrollment, plans were required to submit the number of providers that were in their network in targeted zip codes. California identified these zip codes as areas with high concentrations of uninsured children. Plan selections were based on the ability of plans to serve these zip codes. Many plans were also required to undergo a review by their regulatory state agency, California Department of Corporations which included a review of the adequacy of their network. In addition to an infrastructure of "choice", the State attempts to generate "demand" for services by providing subscribers information on preventative care. The State also collects data from plans and subscribers on access to care.

Health Care Choices

The Healthy Families Program provides a *variety of choices* to the subscriber. HFP offers 25 health and 4 dental plans, thus providing choice in 100% of the 58 counties in the State. Innovative approaches to encouraging the use of traditional and safety net providers have been implemented with much success. Subscribers are allowed to switch health or dental plans 30 days after the first date of their enrollment in a plan and annually during open enrollment.

Rural Health Demonstration Project (RHDP)

For the rural areas, California has initiated a Rural Health Demonstration Project. This project is designed to increase the number of providers or enhance the access to providers in rural areas of the state. As of July 1998, the RHDP has funded 86 different projects. Since July 1998, $12 million has been encumbered; $6 million for projects that enhance access to care for children with migrant and seasonal worker parents and $6 million for projects that increase the number of providers in a geographic area. This funding has been allocated to projects throughout California concentrating on clinics in rural counties that are geographically isolated, or counties with high concentrations of special populations that may be linguistically isolated or otherwise not afforded access to health, dental or vision insurance.

In addition to the RHDP, MRMIB has made available a *Rural Health Plan combination* designated as a statewide plan choice providing access to migrant and seasonal farm workers, native Americans, and children of families working in the fishing and forestry industry. The plan is a combination of health, dental and vision insurance. Healthy Families subscribers who identify themselves as one of the above groups can enroll in this program and receive access to services anywhere in the state, regardless of their county of residence, as long as they remain California residents.

Projects throughout the State range in complexity; from increasing the normal business hours to provide services in the evenings and weekends to TeleMedicine projects and mobile dental clinics.

The types of projects funded through MRMIB differ from county to county depending on local needs. The goal is to fund projects that satisfy the needs and best serve the interests of the HFP participants.

Specialized Care Networks

Participating health, dental and vision plans are required to refer children with special health care needs to the California Children's Services program (CCS) or County Mental Health. CCS and County Mental Health programs are required to conduct a timely assessment of referrals to determine whether a child is medically eligible for CCS or County Mental Health services. The coordination of referrals and provision of service is routinely monitored by staff.

American Association of Pediatrics Guideline for Preventive Care

Plans are required to provide preventive services to children and adolescents in accordance with AAP guidelines. The plans are also required to send an informational brochure on the AAP recommended preventive care screening to all subscribers. The program also includes a copy of these guidelines in the HFP handbook. The provision of preventive care will be monitored through the collection of quality measures and member satisfaction surveys.

Informing Materials

Applications, handbooks, and marketing materials that describe benefits have been printed in 11 languages. In addition, toll-free outreach and information services are available in 11 languages. All plans are required to provide written information on how to use plan benefits, access providers and where to call for questions. This information can also be provided by plans through their toll free customer service centers. In addition, the Network Information System (an online provider directory) lists plan providers with gender, language skills of office staff, address and provider specialty. The State reviews these materials to ensure that access to care is adequately described for subscribers, and that the written document (Evidence of Coverage booklet) is translated into other languages.

Grievance/Complaints

Each year, plans report the number of grievances they received during the previous calendar year and the subject of these grievances. One of the categories included in the report is access to care. This information, along with direct calls from enrollees enables MRMIB to monitor access to care. In addition to these grievance reports, the State receives a significant number of calls from applicants regarding questions or complaints. By tracking the complaints by plan and geographical region, the State is able to monitor access to care. Access to care will also be monitored through consumer satisfaction surveys.

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1			
Approaches to monitoring access	Medicaid CHIP Expansion Program (CA Medi-Cal Program)	State-designed CHIP Program	Other CHIP Program* AIM
Appointment audits	MCO		
PCP/enrollee ratios	MCO		
Time/distance standards	MCO		
Urgent/routine care access standards	MCO	MCO,FFS	
Network capacity reviews (rural providers, safety net providers, specialty mix)	MCO	MCO,FFS	
Complaint/grievance/ disenrollment reviews	MCO	MCO,FFS	MCO,FFS
Case file reviews			
Beneficiary surveys	MCO	MCO,FFS	MCO,FFS
Utilization analysis (emergency room use, preventive care use)	MCO		
Other (specify) Onsite for Rural Demonstration Project		MCO,FFS	
* Regulatory Licensing standards	MCO	MCO,FFS	MCO,FFS
Other (specify) _____			

* Plans participating in the program must comply with access standards that are established by their regulatory licensing agency. The processes that are used for the HFP build on the regulatory activities which ensures that standards for access to care are being met.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program (CA Medi-Cal Program)	State-designed CHIP Program	Other CHIP Program* AIM
Requiring submission of raw encounter data by health plans	_X_ Yes ___ No	___ Yes _X_ No	_X__ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	_X_ Yes ___ No	_X__ Yes ___ No	___ Yes _X_ No
Requires submission of encounter data by vision plans	___ Yes ___ No N/A	_X__ Yes ___ No	___ Yes _X_ No

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Data on access to care will be available after December 31, 2000.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

The Healthy Families Program is collecting quality measures and member satisfaction data to monitor access to care by SCHIP subscribers. This includes annual dental/vision (HEDIS) data on the number of children who have received an initial health assessment within the first four months of enrollment. The quality measures that are required to be supplied by the health plans include:

Immunization Status: Childhood Immunization Status.(Based on HEDIS)
The percentage of enrolled children who turned two years old during the reporting year, who were continually enrolled for 6 months immediately preceding their second birthday (including members who have had not more than one break in enrollment of up to 45 days during the 12 months immediately preceding their second birthday), and who have received the following immunizations:

- Four DTP or DtaP vaccinations by the second birthday
- Three polio (IPV or OPV) vaccinations by the second birthday
- One MMR between the first and second birthdays
- At least on influenza type b vaccination between the first and second birthdays
- Two hepititis B vaccinations by the second birthday(with one of them falling between the six month and the second birthday)
- A combined rate including children who have received all the immunizations above

Access

Children's access to primary care providers looks at visits to pediatricians, family physicians, and other health care providers in a way to assess general access to care for children. Three separate measures are reported:

- Percentage of children ages12 through 24 months who have had one or more visits with a health plan primary care provider during the reported year
- Percentage of children ages 25 months through 6 years who have had one or more visits with a health plan primary care provider during the reported year
- Percentage of children ages 7 years through 11 years who have had one or more visits with a health plan primary care provider during the reported year

Use of Services

A well child visit in the third, fourth, fifth and sixth years.

- The percentage of enrolled members who were age 3 through 6 years during the reporting year, who were continuously enrolled during the reporting year, who received one or more well-child visit(s) with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Adolescent well-child visits

- The percentage of enrolled members who were age 12 through 19 years during the reporting year, who were continuously enrolled during the reporting year, who received one or more well-child visit(s) with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

Follow-up hospitalization for selected mental illness

The percentage of plan members age 6 and over who were hospitalized for selected mental disorders and who were seen on an outpatient basis by a mental health provider within 30 days after discharge.

Annual Dental Visit

The percentage of enrolled members who were age 4 through 19 years during the reporting year, who were continuously enrolled during the reporting year. who received at least one dental visit during the reporting year. Members who have had no more than one gap in enrollment of up to 30 days during the reporting year should be included in this measure.

HFP is also planning a consumer satisfaction survey to be conducted in the fall of 2000. The State will also monitor access to care in dental plans by collecting quality data.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1			
Approaches to monitoring quality	Medicaid CHIP Expansion Program (CA Medi-Cal Program)	State-designed CHIP Program	Other CHIP Program AIM
Focused studies (specify)	MCO – Pediatric, Preventive Services, Prenatal Care		
Client satisfaction surveys	MCO	MCO/FFS	MCO/FFS
Complaint/grievance/ disenrollment reviews	MCO	MCO/FFS	MCO/FFS
Sentinel event reviews			
Plan site visits	MCO		
Case file reviews	MCO		
Independent peer review			
HEDIS performance measurement	MCO	MCO/FFS	
Other performance measurement (specify) 120 Day Health Assessment	MCO	MCO/FFS	
Other (specify) Dental Quality Measures		MCO/FFS	
Other (specify) _____			
Other (specify) _____			

There are several sources of data that are used to monitor plan quality and service in the HFP. Some of the data sources are reports that are contractually required; other sources of data are external to the plans. The combination of plan reported data and data collected external to the plans provides sufficient information to identify areas of deficiencies, and enables staff to request specific corrective action.

Sources of data used to monitor plan performance are as follows.

Fact Sheets
Fact Sheets are submitted by each health, dental and vision plan interested in participating in the Healthy Families Program. The questions that are included in the Fact Sheet request information about the organization of the plans and the provision of health, dental and vision care services. Some of the specific areas that are addressed include access to providers, access to plan services, including customer service, standing with regulatory entity or accrediting body, and process for handling member grievances. Fact Sheets are submitted by the plans annually.

Annual Subscriber Grievance Reports
Participating health, dental and vision plans are required to submit an annual Subscriber Grievance Report. This report shows the number of grievances received from each plan's subscribers and the reasons for these grievances. Categories of grievances that plans must report include access to care (including telephone service and language accessibility), quality of care, benefit coverage, claims, and referrals. The information provided in the subscriber grievance reports is trended over time for each participating plan. Staff also compares the grievance reports with the complaints MRMIB receives from HFP subscribers (or applicants on behalf of subscribers) and with results from member surveys to uncover particular problems that may exist with a plan.

Annual Quality of Care Reports
Each year, health and dental plans are required to submit quality of care reports based on HEDIS and a 120-day health (or dental) assessment measure. The HEDIS reports for health plans focus on the number of children who have been immunized and on the number of children receiving well child visits. Health plans also report the number of children receiving an outpatient visit after being admitted to the hospital for mental illness. Dental plans report the number of children receiving an annual dental visit using HEDIS, and will report the proportion of children that have received dental sealants, prophylaxis, a periodic examination and an initial examination. The 120-day initial health and dental assessment is designed to measure the proportion of children being seen for an assessment within the first four months of their initial enrollment. Because preventive care is vital to young children and is the cornerstone of care provided through the HFP, the annual quality of care reports provide an indication of how well a particular plan is providing health or dental care to members.

California Children Services (CCS) and Mental Health Referral Reports
The CCS and Mental Health Referral Reports are designed to monitor the access that eligible children have to the CCS and county mental health services. Plans are required to report on a quarterly basis the number of children referred to these services. The numbers reported by plans will be compared with the estimates of children expected to require CCS and county mental health services to determine whether there is adequate access to these services. In addition to these reports, regular meetings are held with plans and the CCS and county mental health programs to discuss issues related to access to referrals and coordination of care.

Cultural and Linguistics Services and Group Needs Assessment Reports
This report allows staff to monitor whether special needs of HFP subscribers related to language access are being met. The Cultural and Linguistic Services Report outlines how plans will provide culturally and linguistically appropriate services to subscribers and how they will meet the health education needs of limited English proficient subscribers. The effectiveness of a plan's process for providing adequate language access and access to culturally appropriate services will also be monitored through the annual subscriber grievance reports, member surveys, and complaints MRMIB receives from applicants.

Welcome Calls
EDS, the enrollment vendor for the HFP, makes welcome calls to families of each subscriber when they first enroll. These calls, which are made between the 10th and the 20th day of enrollment, allow staff to monitor whether subscribers are receiving their identification cards, and their Evidence of Coverage booklets as required by the contract. To complement information that is obtained through the welcome calls, plans submit copies of their welcome packages to MRMIB annually. (Welcome packages include Evidence of Coverage booklets, plan identification cards and provider directories. These packages are provided to new subscribers soon after enrollment, and to continuing subscribers annually.) By receiving copies of the welcome packages, staff can verify whether the identification cards, Evidence of Coverage, and preventive care reminders meet the HFP contract requirements.

Member Surveys
MRMIB uses two member surveys to monitor quality and service. During open enrollment, all subscribers are given a plan disenrollment survey. The survey requests information on why HFP members switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. The comparison of disenrollment trends and results from the disenrollment surveys provide another tool for monitoring plan performance. The second survey will be a consumer satisfaction survey, based on CAHPS, that will be conducted in Fall 2000.

Subscriber Complaints
MRMIB receives direct inquiries and complaints from HFP applicants. Ninety percent of the inquiries are received via correspondence and ten percent through phone calls. All HFP inquires and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the families' primary languages and type of request. This data enables staff to track complaints by plan and to: 1) monitor access to medical care by plan, 2) evaluate the quality of health care being rendered by plan, 3) evaluate the effectiveness of plans in processing complaints and 4) monitor the plan's ability to meet the linguistic needs of subscribers.

On-site Visits
On-site visits to plans allows staff to examine first hand, the systems that plans have implemented for delivering services as described in the Fact Sheets. For example, an on-site visit allows staff to observe how language services are made available to subscribers at the plan, or how grievances are processed through the plan's grievance resolution process. On-site activities may include reviewing plan policies and procedures for resolving grievances, Primary Care Physician assignment and quality management.

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Please see prior question 4.5.1 for a comprehensive description of quality monitoring information.

Open Enrollment Survey

The Healthy Families Program conducted its first Open Enrollment (OE) period from April 15, 1999 to May 31, 1999. A total of 4.24% of families with an option to change elected to change health plans; a relatively low percentage.

In order to provide Healthy Families Program partners with more individualized feedback regarding the OE period, MRMIB developed a survey to address reasons why members switched plans. This survey represented responses from 641 of those enrollees. The scores ranged 1 to 5 with 5 being the highest level of customer satisfaction. The distribution of scores ranged from 1.52 to 2.72 for plans with over 25 members transferring out. The primary reason for changing plans was the perception that a different plan would offer improved care and a greater choice of doctors.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

Quality Improvement Workgroup/Quality Accountability Framework

Through a grant by the California Healthcare Foundation, the Quality Accountability Framework was developed specifically for the Healthy Families Program. The framework outlines strategies for monitoring quality and making plans accountable for the services that they deliver. The State endorsed the Quality Accountability Framework and convened a workgroup to provide recommendations for implementing the strategies. To date the following recommendations have been adopted.

The Quality Improvement Workgroup (QIWG) developed recommendations for implementing the Quality Accountability Framework for the HFP. The recommendations pertained to 3 domains outlined in the framework. Recommendations were presented, reviewed and approved by the HFP Advisory Board and either adopted by MRMIB or deferred until 2000. These domains included:

- Quality Measures
- Quality Management Processes
- Contract Strategies

<u>1) Quality Measures</u>

- Cultural and Linguistic Aspects of quality: quality data collected by plans be constructed in a manner that allows linkage to the HFP enrollment files
- Health Plans to provide the five categories of HEDIS measures relevant to children one through nineteen years of age. Adolescent Health survey developed by the Foundation for Accountability (FACCT) as a replacement for the adolescent immunization measure

- The Medicaid version of CAHPS 2.0(H) survey will be used to assess satisfaction with access, customer service and care among ethnic, language and age
- Implement a DHS defined 120 day health assessment and the Pediatric Quality of Life (PedsQL) survey to assess changes in health status of HFP members

Cultural and Linguistic Aspects of Quality
The HFP implemented a process where quality data collected by plans is constructed in a manner that allows linkage to the HFP enrollment files. This linkage will enable MRMIB and the plans to aggregate quality data by ethnic, language, and other demographic variables to examine difference in quality among these groups. Initial reports may be inconclusive since data collected will be based on small numbers within each plan. However, as the program matures and enrollment increases, reports by ethnic and language groups should become more meaningful.

Dental Quality
Four additional measures should be incorporated into the HFP contracts for 1999. The four measures identified by the Work Group are based on the work that was done by the Department of Corporations Dental Quality Task Force. These measures include:

- Sealants per 100 children
- Prophylaxis per 100 children
- Initial examinations per 100 children
- Periodic examinations per 100 children

The Work Group recommended that the dental plans collect data on sealants per 100 children to test the validity of the data collected and to refine the specifications of this new measure. Plans should use plan-wide data to report this measure. Data reported on this measure in the year 2000, based on 1999 Healthy Families enrollment will serve as a baseline for performance with this service. The other measures should be required of plans to be reported in the year 2000. As with the measure on sealants, the first report submitted by dental plans on these other three measures should be used to test the validity of the measure. The second report, to be submitted in 2001 would provide a baseline for plan performance with these services.

The State will be considering the following additional strategies in 2000 to promote the provision of quality care by plans:

<u>2) Quality Management Processes</u>
These "stretch" measures were recommended to distinguish plans based on quality
- Highest tier or NCQA or JCAHO accreditation
- Plans compensation of providers links a significant percentage of payment to the provider's quality management or quality care received
- Plan commitment to and compliance with information systems advances specified by the California Health Care Information Summit

- Annual application of a standardized survey of children's physical, mental and social health resource. Measuring and continuously improving compliance with USPTF recommendations on health guidance
- Measuring and continuously improving at least one of the clinical interventions recommended by Children Now, to expand clinical responsibility for child development.
- Demonstration of systematic integration (in problem identification and intervention) with schools and other community institutions that play a vital role in the health and well being of children

3) Contract Strategies/Incentives/Disincentives for Quality

- All plans will need NCQA accreditation for program continuance and renewal
- Provide incentives to enrollees to choose more highly rated plans by reducing premiums
- Measuring and continuously improving compliance with AAP-endorsed guidelines for common conditions relative to 1 to 19 year olds.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Section 5. Reflections

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

What Worked / Best Practices

- After a major revision of the joint HFP/MCC application from 28 pages to 4 pages and implementation of a "*single point of entry*" for all children's applications, the mail-in application process was successful in providing seamless application and eligibility determination
- The 12-month continuous eligibility policy for the HFP helped in providing continuity of coverage. It also made the program administratively simple for families
- Minimal documentation requirements eased the application process
- Linguistic diversity in application materials and the toll-free support lines minimized access problems related to language
- A centralized and local administrative vendor allowed HFP/MCC management to monitor, evaluate and provide input on administrative issues on a face-to-face basis
- Public disclosure of enrollment data on the Website facilitated interest group trust in program administration and provided immediate public accountability

Lessons Learned

- The original 28-page application was an excellent training tool for CBOs and CAAs, but it was not effective as an application. This application was revised early in the program implementation
- Establishing performance measures for the administrative vendor is crucial to administrative success and accountability

Evaluation Efforts

- Assessed and evaluated the number of applicants assisted by a CAA
- Evaluation of CAA training through the tracking of CAA application errors
- Conducted case reviews at administrative vendor to insure current income calculations and appropriate documentation submission

5 1.2 Outreach

What Worked / Best Practices

- Performance based reimbursement to community based groups allowed the outreach message to be spread throughout a large geographic and ethnically diverse state
- Schools were a very good vehicle for outreach
- Public Relations/Sponsorship campaign created a statewide familiarity with the HFP/MCC brand
- Ethnic media was effective in advertising the HFP in targeted communities
- Advertising proved to significantly increase awareness and calls to the toll-free outreach telephone lines

Lessons Learned

- The 10% cap can limit the success of the initial program implementation. The effort and expense of the program in the early years (with a limited enrollment base) is substantial and the 10% cap is unrealistic
- Federal policies can have a negative affect in achieving the objectives of the program(e.g. public charge)
- Training is crucial to community based partners efforts to educate and enroll children. Resources need to be fully directed toward the training effort
- The joint campaign and logo may have helped to improve the image of the Medi-Cal program and may have hindered HFP enrollment
- Diversity dictates flexibility. An outreach strategy must be multi-faceted to successfully reach diverse populations
- Immigration issues continue to impact the program. Even with clarification of the public charge issue by INS, some families and advocates are reluctant to approach the HFP because of prior negative experiences and a general distrust of government
- Coordination with outreach partners is very important in both design and implementation
- Direct mail to Share of Cost Medi-Cal families did not result in requests for applications

Evaluation Efforts

- Assess the change in call volume to the toll-free lines on heavy media days
- Evaluate the volume and sources of application fees paid
- Analyze the growth and ethnic distribution of enrollment
- Track the number of applications distributed and submitted
- Analyze the portion of the total estimated population that has been enrolled
- Track the number of calls to toll-free telephone lines in total and by ethnicity

5.1.3 Benefit Structure

What Worked / Best Practices

- High interest by families in the HFP dental benefits indicated that dental "un-insurance" is a serious concern to families
- Providing comprehensive health, dental and vision benefits reached the critical needs of the target population and allowed children with special health care needs to continue accessing specialty care networks that were designed especially for them
- Families like the idea that benefits are equal to the "best benefits" available in the employer based market

Lessons Learned

- More is always better in the public's perception on benefits
- Providing coverage based on a commercial product allowed plans and staff to compare HFP utilization with commercial utilization: gave program a better sense of "risk pool" involved
- Federal Vaccine for Children policy penalized non-Medicaid expansion states and created perception problems with the provider community. State was forced to create a workaround
- Low cost sharing rules for benefits makes coordination with employer plans difficult
- Dental coverage is a magnet to enrollment
- Using the State employee benefit package facilitated building consensus on benefits
- "Crowd out" does not seem to be an issue even with the HFP rich benefits
- Most of the children in HFP "referred" to CCS and County Mental Health are believed to be existing cases, not new cases. The HFP is providing these children with comprehensive coverage

Evaluation Efforts

- Grievances and complaints received from HFP subscribers
- HEDIS, Consumer Satisfaction Survey and Health Status Survey results will provide insights on whether the scope of benefits had an impact on the health of children served

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

What Worked / Best Practices

- Payment options (check, cash at a designated pay station, money order, credit card) are being utilized, allowing ease of access
- Subscribers took advantage of the $3 per month discount offered through the Community Provider Plan with 42% choosing the discount CPP option
- Program design eliminates the possibility of exceeding the 5% cap

Lessons Learned

- Program design coordination with CCS and County Mental Health can help families with seriously ill children
- An unintended consequence of the HFP is that costs will increase and benefits decrease when subscribers transition to employer based coverage
- An insignificant number of families (26 out of 178,000 children) exceeded the $250 copayment maximum for health benefits
- Premiums have not been a deterrent to enrolling or retaining children on the program
- Cash pay stations appear to be a popular vehicle for subscribers to pay their premium (41%)

Evaluation Efforts

- Development of a tracking report identifying subscribers that exceeded the $250 copayment maximum
- Questions related to the subscriber's willingness to pay and perceived value of paying premiums have been included on surveys

5.1.5 Delivery System

What Worked / Best Practices

- An incentive to include T&SN providers in the networks has been successful. Children are choosing plans that offer the T&SN providers (42% of total subscribers)
- The Healthy Families Purchasing Pool model has encouraged participation of a broad network of providers plans
- Partnerships with plans and augmented funding can improve access in rural areas and to special populations
- Network information including physicians, language, gender and specialty available on the HFP internet website promotes choice for families
- Providing a structure for private plans to partner with public programs in providing care(e.g., TitleV- Children with Special Health Needs) can be effective

Lessons Learned

- Families like choice of plans and products
- Competition between plans is valuable in holding down costs, improving customer service and increasing participation of plans
- Adopting Medicaid based standards in the HFP has created tension with plans
- Public sentiment regarding managed care impacts public perception of the programs
- HMOs are not available in all rural areas. The program needs an Exclusive Provider Organization to cover the entire state
- Subscribers do not show a large propensity to change plans
- Community based clinics are eager to participate in the program

Evaluation Efforts

- Quality reports and customer surveys will provide insights on whether the delivery system has had an impact on the health of children served
- Analysis of annual enrollment, disenrollment statistics, disenrollment surveys
- Analysis of administrative vendor database

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

What Worked / Best Practices

- Joint application and identical eligibility standards for HFP and MCC make it easier for families and CAAs to complete applications
- Building on existing programs such as CCS guarantees continuity of care. With plans participating in both programs (via MOU), families with children in both can have a single network
- Development of a common set of responsibilities via MOUs provided the foundation for establishing necessary relationships between the plans and CCS/County Mental Health
- Early coordination of services between the state programs, regular meetings with plans, local program staff and designated liaisons for each involved entity proved valuable

Lessons Learned

- Some families want SCHIP but are MCC eligible
- The public perception of INS issues made it difficult to coordinate outreach efforts with programs that considered themselves immigration "safe harbors"
- Many established programs share the goal of health insurance for children and are willing to help with outreach
- SCHIP can help elevate the image of Medicaid
- New ideas like the mail in application, less restrictive documentation standards and toll-free telephone assistance, implemented in the Healthy Families Program, have impacted Medi-Cal for Children administration
- A concentrated effort is required to foster coordination between health, dental and vision plans with CCS and County Mental Health
- Duplication in documentation requirements can be eliminated through ongoing communication
- Crowd-out under the HFP/MCC has failed to materialize in any significant degree

Evaluation Efforts

- Track referrals to CCS and county Mental Health
- Monitor progress of Memorandum of Understandings (MOUs) between plans and coordinating programs (CCS, County Mental Health)
- Communicate with other programs involved in outreach and providing health services

5.1.7 Evaluation and Monitoring (including data reporting)

What Worked / Best Practices

- A variety of program statistics capturing age, ethnicity, gender, income levels, and geographical distribution are available on the Managed Risk Medical Insurance Board website *('www.mrmib.ca.gov')*. Over 15,000 people have visited the site since its creation
- MRMIB is a public board that assures public participation in the decision making process

Lessons Learned

- Public participation provides an early warning system on policy and customer service issues
- Coordination with the administrative vendor, outside consultants, and other related State programs on data assessment and reporting is a very important component of successful program evaluation

Evaluation Efforts

- Quality reports
- Member Surveys
- "Welcome calls" to survey and assist new subscribers
- Open enrollment reporting
- Copayment reporting
- Constant communication with stakeholders
- Traditional and Safety Net Provider reporting
- A comprehensive application, enrollment, financial reporting and budgeting system has been established

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

- *Extend enrollment up to 250% of FPL*
  On November 23, 1999, California received approval to extend enrollment in the HFP to children in families with incomes of up to 250% FPL. On November 24, 1999, the HFP began enrolling these newly eligible children. Over 5,000 letters were mailed to families who were previously denied enrollment because their income exceeded 200% FPL but was less than 250% FPL.

- *Continue to grow and promote the Rural Health Demonstration Project*
  The HFP has taken the necessary steps to ensure that children have access to health, dental and vision care in rural communities of California by funding 86 projects that directly address the elimination of barriers to health care access. Families are informed of this project through existing outreach efforts. Some of the key projects include:
    - Tele-medicine
    - Mobile dental vans
    - Saturday clinics
    - Extending clinic hours
    - Transportation services
    - Requests to hire bilingual and multi-cultural staff

  California will continue to fund this project in future years based on legislative approval.

- *Maintain the incentives and actively promote the inclusion of Traditional and Safety Net Providers in health care networks*
  The incentives that were given to plans to include Traditional and Safety Net Providers have been successful. The State will continue its efforts to promote the inclusion of these providers in health care networks.

- *Implement third party sponsor amendments*
  On March 6, 2000 California received approval to establish a "sponsorship" process to allow third parties to pay premiums on behalf of applicants. The State pursued this payment option as a means of drawing local charitable organizations into the outreach process, and as a means of helping uninsured families learn about insurance coverage. Via the sponsorship program, "sponsors" will pay the first year's premiums for subscribers. The opportunity for these families to secure funding for their premiums through sponsors will result in more children enrolling and retaining their coverage through the HFP.

- *Implement cultural and linguistic standards for participating health, dental and vision plans*
  Specific requirements related to interpreter services, translation of written materials and assessment of the linguistic and health education needs of enrollees have been included in all health, dental and vision plan contracts. These requirements highlight the State's efforts to ensure that plans provide equal access to health care services to subscribers regardless of their English language proficiency.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

- Allow families who have health insurance coverage for their children, but no dental or vision insurance coverage to enroll for the dental and vision component of SCHIP
- Modify rules to allow greater coordination with employer sponsored plans
- Offer families a choice between the Healthy Families Program and Medi-Cal for Children, irrespective of the family's income eligibility
- Establish SCHIP as a permanent program
- Expand the SCHIP to include parents
- Permit expenditures above the 10% administrative cap during the first 3 years of program implementation
- Recommend that HCFA advance the rapid adoption of standards for waivers
- Make federal Vaccination for Children vaccines available to SCHIP subscribers